Application for a §1915 (c) HCBS Waiver

HCBS Waiver Application Version 3.5

Includes Changes Implemented through May 2014

Submitted by:

Utah Department of Health, Division of Medicaid and Health Financing

Submission Date:	March 31, 2021

CMS Receipt Date *(CMS Use)*	

Describe any significant changes to the approved waiver that are being made in this renewal application:

This renewal includes the following changes to the waiver:

-addition of Non-medical transportation through the Utah Transportation Authority (UTA)
-correction of terminology throughout the document to reflect current agency titles and responsibilities
-updates to performance measures to align with similar programs managed by the Operating Agency
-eligibility modification of age for individuals with disabilities to ensure individuals over 65 may qualify for the Medicaid Work Incentive (MWI) deductions

State:	
Effective Date	

Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE

HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors.

Application: 1

State:	
Effective Date	

1. Request Information

A. The **State** of **Utah** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. **Program Title** (*optional – this title will be used to locate this waiver in the finder*): **Physical Disabilities Waiver**

C. **Type of Request:** *(the system will automatically populate new, amendment, or renewal)*

Requested Approval Period: (*For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

✦	**3 years**
✦	**5 years**

×	**New to replace waiver** Replacing Waiver Number:		
×	**Migration Waiver** – this is an existing approved waiver Provide the information about the original waiver being migrated		
	Base Waiver Number:		
	Amendment Number (if applicable):		
	Effective Date: (mm/dd/yy)		

D. **Type of Waiver** *(select only one)*:

✦	**Model Waiver**
X	**Regular Waiver**

E. **Proposed Effective Date:** 07/01/21

Approved Effective Date *(CMS Use):*

F. **Level(s) of Care**. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan *(check each that applies)*:

×	**Hospital** *(select applicable level of care)*	
	✦	**Hospital as defined in 42 CFR §440.10**

State:	
Effective Date	

		If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:
	✦	**Inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160**
X	**Nursing Facility** *(select applicable level of care)*	
	X	**Nursing Facility as defined in 42 CFR §440.40 and 42 CFR §440.155** If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
	✦	**Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**
×	**Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)** If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID facility level of care:	

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

X	**Not applicable**
✦	**Applicable**

Check the applicable authority or authorities:

×	**Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**
×	**Waiver(s) authorized under §1915(b) of the Act.** *Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:*

Specify the §1915(b) authorities under which this program operates (*check each that applies*):

×	§1915(b)(1) (mandated enrollment to managed care)	×	§1915(b)(3) (employ cost savings to furnish additional services)
×	§1915(b)(2) (central broker)	×	§1915(b)(4) (selective contracting/limit number of providers)

×	**A program operated under §1932(a) of the Act.** *Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:*
×	**A program authorized under §1915(i) of the Act.**
×	**A program authorized under §1915(j) of the Act.**
×	**A program authorized under §1115 of the Act.** Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

X	**This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The PD Waiver program provides services and supports to people with significant physical disabilities as described in Appendix B-1 who live in the community. It is designed to be consistent with a service delivery system that promotes and supports participant self-determination, maintains a high standard of quality in services and supports and maximizes the distribution and utilization of public funds, both state and federal. The SMA has entered into an interagency agreement for the day-to-day administration and operation of the PD Waiver with the Utah Department of Human Services, Division of People with Disabilities (DSPD). The SMA retains final administrative authority over the PD Waiver program.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. *(Select one)*:

X	**Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
✦	**No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. **Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

✦	**Not Applicable**
✦	**No**
X	**Yes**

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

X	**No**
✦	**Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

×	**Geographic Limitation**. A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State. S*pecify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area*:
×	**Limited Implementation of Participant-Direction**. A waiver of statewideness is requested in order to make ***participant direction of services*** as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State. *Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area*:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services.

Appendix B specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR §440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through

its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified throughout the application and in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:

The SMA together with the Division of Services for People with Disabilities (DSPD) prepared an initial draft of the waiver renewal application in August 2020. The SMA and DSPD then convened a workgroup consisting of advocates, providers, parents, PD Waiver participants and others to discuss potential improvements and updates to the Waiver program. Updates to the renewal application were then crafted based on feedback from the workgroup.

Beginning January 31, 2021, and for 30 days thereafter, a copy of the draft State Implementation Plan was posted online at http://health.utah.gov/ltc. Public comment was accepted by mail, fax and online submission. In addition, the State presented information on the waiver amendment to the Utah Indian Health Advisory Board (UIHAB) at their February 2021 meeting. The UIHAB represents all federally recognized Tribal Governments within the State. Additionally, a summary of the changes was supplied to the Medical Care Advisory Committee (MCAC) during their January 2021 meeting. Information on the amendment was published in the newspaper with instructions on how a copy of the implementation plan could be requested and how comments may be submitted. Hard copies were also made available at the Department of Health.

J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date as provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:	Ambrenac				
First Name:	Josip				
Title:	Director, Bureau of Authorization and Community Based Services				
Agency:	Department of Health, Division of Medicaid and Health Financing				
Address :	288 N. 1460 W.				
Address 2:	PO Box 143112				
City:	Salt Lake City				
State:	Utah				
Zip:	84114-3112				
Phone:	(801) 538-6090	**Ext :**		×	**TTY**
Fax:	(801) 323-1588				
E-mail:	jambrena@utah.gov				

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:	Pinna				
First Name:	Angie				
Title:	Division Director				
Agency:	Department of Human Services, Division of Services for People with Disabilities				
Address:	195 N. 1950 W.				
Address 2:					
City:	Salt Lake City				
State:	Utah				
Zip :	84116				
Phone:	(801) 448-1782	**Ext :**		×	**TTY**
Fax:	(801) 538-4279				
E-mail:	apinna@utah.gov				

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:

_____

State Medicaid Director or Designee

Submission Date:	

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name:	Checketts				
First Name:	Nate				
Title:	Deputy Director				
Agency:	Utah Department of Health Division Director, Division of Medicaid and Health Financing				
Address:	288 N. 1460 W.				
Address 2:	PO Box 143112				
City:	Salt Lake City				
State:	Utah				
Zip:	84114-3112				
Phone:	(801) 538-6043	**Ext:**		×	**TTY**
Fax:	(801) 538-6860				
E-mail:	nchecketts@utah.gov				

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The state assures that this waiver renewal will be subject to any provisions or requirements included in the state's most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any CMS required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

The State conducted its preliminary categorization by describing services as either "presumed to be compliant" or "requires additional review." In addition, a listing of provider types and the number of providers has been supplied to help assess the scope of the in-depth reviews that will occur in the upcoming months.

The Department of Health took a conservative approach when designating providers as "presumed to be compliant". The State only identified services as "presumed to be compliant" when the services are not dependent on the setting and are direct services provided to the waiver participant. In addition, providers that offer multiple types of services, were categorized as "requires additional review" if the provider had any possibility of providing a service that may not be compliant.

No Physical Disabilities Waiver providers were identified as requiring additional review.

Appendix A: Waiver Administration and Operation

1. State Line of Authority for Waiver Operation. Specify the state line of authority for the operation of the waiver *(select one)*:

✦	The waiver is operated by the State Medicaid agency. Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one)*:		
	✦	The Medical Assistance Unit *(specify the unit name) (Do not complete Item A-2*)	
	✦	Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit. Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency. (*Complete item A-2-a)*	
X	The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency. Specify the division/unit name:		
	The Division of Services for People with Disabilities (DSPD)		
	In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. (*Complete item A-2-b).*		

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

The Home and Community Based Services Waiver-Division of Services for People with Disabilities Interagency Agreement (Interagency Agreement) between the State Medicaid Agency (SMA) and DSPD sets forth the respective responsibilities for the administration and operation of the PD Waiver. This Interagency Agreement runs for a five year period, but can be amended as needed.

The Interagency Agreement delineates the SMA's overall responsibility to provide management and oversight of the PD Waiver, as well as DSPD's operational and administrative functions.

The responsibilities of DSPD as the Operating Agency (OA) are delegated as follows. Most of these responsibilities are shared with the SMA:

1. Program Development
2. Rate Setting and Fiscal Accountability
3. Program Coordination, Education and Outreach
4. HCBS Waiver Staffing Assurances
5. Eligibility Determination and Waiver Participation Assurances
6. Waiver Participant Involvement in Decision Making
7. Hearings and Appeals
8. Monitoring, Quality Management and Quality Improvement
9. Reporting
10. Data Security

The SMA monitors the Interagency Agreement through a series of quality assurance activities, provides ongoing technical assistance and reviews and approves all rules, regulations and policies that govern PD Waiver operations. There is a focused program review conducted annually by the SMA Quality Assurance Team. If ongoing or focused annual reviews conducted by the SMA Quality Assurance Team reveal concerns with compliance, DSPD is required to develop plans of correction within specific time frames to correct the problems. The SMA Quality Assurance Team conducts follow up activities to ensure that corrections are sustaining.

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (s*elect one)*:

✦	**Yes. Contracted entities perform waiver operational and administrative functions on**

	behalf of the Medicaid agency and/or operating agency (if applicable). Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.*
X	**No**. **Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity *(Select one)*:

X	**Not applicable**
✦	**Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

×	**Local/Regional non-state public agencies** conduct waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state agency that sets forth the responsibilities and performance requirements of the local/regional agency. The interagency agreement or memorandum of understanding is available through the Medicaid agency or the operating agency (if applicable). *Specify the nature of these agencies and complete items A-5 and A-6:*
×	**Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). *Specify the nature of these entities and complete items A-5 and A-6*:

5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities. Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

6. Assessment Methods and Frequency. Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	X	X	×	×
Waiver enrollment managed against approved limits	X	X	×	×
Waiver expenditures managed against approved levels	X	X	×	×
Level of care evaluation	X	X	×	×
Review of Participant service plans	X	X	×	×
Prior authorization of waiver services	X	X	×	×
Utilization management	X	X	×	×
Qualified provider enrollment	X	X	×	×
Execution of Medicaid provider agreements	X	×	×	×
Establishment of a statewide rate methodology	X	X	×	×
Rules, policies, procedures and information development governing the waiver program	X	X	×	×
Quality assurance and quality improvement activities	X	X	×	×

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities..

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. As necessary and applicable, performance measures should focus on:

- ***Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver***
- ***Equitable distribution of waiver openings in all geographic areas covered by the waiver***
- ***Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014).***

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure 1:	*# & % of applicants denied access to the waiver following the initial LoC eval who were provided timely notice of appeal rights. Numerator is the total # of applicants who were denied waiver access after the initial LoC and received a timely notice of appeal rights at least 10 days before the date of action; denominator is the total # of applicants denied waiver access after the initial LoC*
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	

State:	
Effective Date	

DSPD Annual reports and DSPD Annual Incident report			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation :*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X State Medicaid Agency	*✗ Weekly*	*X 100% Review*
	X Operating Agency	*✗ Monthly*	*✗ Less than 100% Review*
	✗ Sub-State Entity	*✗ Quarterly*	*✗ Representative Sample; Confidence Interval =*
	✗ Other Specify:	*✗ Annually*	
		X Continuously and Ongoing	*✗ Stratified: Describe Group:*
		✗ Other Specify:	
			✗ Other Specify:

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
X State Medicaid Agency	*✗ Weekly*
X Operating Agency	*✗ Monthly*
✗ Sub-State Entity	*✗ Quarterly*
✗ Other Specify:	*X Annually*
	✗ Continuously and Ongoing
	✗ Other Specify:

Performance Measure 5:	*# and percentage % of participants who have a) had a reduction/denial of a waiver service; b) been denied choice of provider if more than one was available; or c) been determined ineligible when previously receiving services, who were provided timely notice of appeal rights. N = # of compliant cases in compliance; D = total # of cases with or without timely notification requiring notification.*
Data Source (Select one) (Several options are listed in the on-line application):	
If 'Other' is selected, specify:	

State:	
Effective Date	

USTEPS			
	Responsible Party for data collection/generation (check each that applies)	*Frequency of data collection/generation: (check each that applies)*	*Sampling Approach (check each that applies)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval =*
	☐ Other Specify:	*X Annually*	*95% Confidence Level, 5% Margin of Error*
		X Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis (check each that applies	*Frequency of data aggregation and analysis: (check each that applies*
X State Medicaid Agency	*☐ Weekly*
X Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*☐ Quarterly*
☐ Other Specify:	*X Annually*
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure 4:	*# and % of newly enrolled waiver providers with a Medicaid provider agreement that has been approved prior to receiving reimbursement for waiver services. Numerator is the total # of newly enrolled waiver providers with approved Medicaid provider agreements in place prior to receiving reimbursement; denominator is the total # of newly enrolled waiver providers*

	receiving reimbursement.		
Data Source (Select one) (Several options are listed in the on-line application):			
If 'Other' is selected, specify:			
The Utah Systems for Tracking Eligibility, Planning and Services (USTEPS)			
	Responsible Party for data collection/generation (check each that applies)	*Frequency of data collection/generation: (check each that applies)*	*Sampling Approach (check each that applies)*
	☐ State Medicaid Agency	*☐ Weekly*	*X 100% Review*
	X Operating Agency	*☐ Monthly*	*☐ Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*☐ Representative Sample; Confidence Interval =*
	☐ Other Specify:	*☐ Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis (check each that applies	*Frequency of data aggregation and analysis: (check each that applies*
X State Medicaid Agency	*☐ Weekly*
X Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*☐ Quarterly*
☐ Other Specify:	*X Annually*
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure 2:	**Number and percentage of docs/rules/policies/procedures submitted to and approved by the SMA using the Document Submittal Protocol prior to implementation. The numerator is the total number of docs/rules/policies/procedures that were appropriately submitted by the OA; the denominator includes both documents that were correctly submitted and any documents that were not correctly submitted for SMA review prior to implementation.**
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	
Document Approval forms and DSPD documents	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation :*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X State Medicaid Agency	*✗ Weekly*	*X 100% Review*
	X Operating Agency	*✗ Monthly*	*✗ Less than 100% Review*
	✗ Sub-State Entity	*✗ Quarterly*	*✗ Representative Sample; Confidence Interval =*
	✗ Other Specify:	*✗ Annually*	
		X Continuously and Ongoing	*✗ Stratified: Describe Group:*
		✗ Other Specify:	
			✗ Other Specify:

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
X State Medicaid Agency	*✗ Weekly*
X Operating Agency	*✗ Monthly*
✗ Sub-State Entity	*✗ Quarterly*
✗ Other Specify:	*X Annually*
	✗ Continuously and Ongoing
	✗ Other

State:	
Effective Date	

	Specify:

Performance Measure 3:	*Number & percentage of participants enrolled in the waiver in accordance with the State Implementation Plan (SIP). Numerator is the number of participants enrolled in the waiver in accordance with the SIP; Denominator is the total number of enrolled waiver participants.*
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	
Rate setting meetings minutes, Approval documentation and Correspondence	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation :*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X State Medicaid Agency	*✗ Weekly*	*X 100% Review*
	✗ Operating Agency	*✗ Monthly*	*✗ Less than 100% Review*
	✗ Sub-State Entity	*✗ Quarterly*	*✗ Representative Sample; Confidence Interval =*
	✗ Other Specify:	*✗ Annually*	
		X Continuously and Ongoing	*✗ Stratified: Describe Group:*
		✗ Other Specify:	
			✗ Other Specify:

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
X State Medicaid Agency	*✗ Weekly*
✗ Operating Agency	*✗ Monthly*
✗ Sub-State Entity	*✗ Quarterly*
✗ Other Specify:	*X Annually*
	✗ Continuously and

State:	
Effective Date	

	Ongoing
	✗ *Other Specify:*

ii. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

The SMA demonstrates ultimate administrative authority and responsibility for the operation of the PD Waiver program through numerous activities including the issuance of policies, rules and regulations relating to the PD Waiver as well as the review and approval of protocols, documents, provider manuals including the PD Waiver provider manual, bulletins, rates and trainings that affect any aspect of PD Waiver operations. The SMA also conducts periodic meetings with DSPD staff, monitors compliance with the Interagency Agreement, conducts focused annual quality assurance reviews of the PD Waiver program and provides technical assistance to DSPD and other entities within the state that affect the operation of the PD Waiver program.

The SMA verifies compliance with the Administrative Authority performance measures at least annually. The SMA is the entity responsible for official communication with CMS for all issues related to the PD Waiver.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.*

Individual issues identified that affect the health and welfare of individual participants are addressed immediately. These issues are addressed in a variety of ways, and may include: a) direct contact for additional information if any, and b) informal discussion or formal (written) notice of adverse findings. The SMA will use discretion in determining notice requirements depending on the findings. Examples of issues requiring intervention by the SMA would include: overpayments; allegations or substantiated violations of health and safety; necessary involvement of APS and/or local law enforcement; or issues involving the State's Medicaid Fraud Control Unit.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis	***Responsible Party*** *(check each that applies)*	***Frequency of data aggregation and analysis:***

State:	
Effective Date	

(including trend identification)		*(check each that applies)*
	X State Medicaid Agency	*✗ Weekly*
	✗ Operating Agency	*✗ Monthly*
	✗ Sub-State Entity	*✗ Quarterly*
	✗ Other Specify:	*X Annually*
		✗ Continuously and Ongoing
		✗ Other Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

X	**No**
✦	**Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

Appendix B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each subgroup in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Select one Waiver Target Group	Target Group/Subgroup		Minimum Age	Maximum Age	
				Maximum Age Limit: Through age –	No Maximum Age Limit
X	**Aged or Disabled, or Both - General**				
	X	Aged (age 65 and older)	65		X
	X	Disabled (Physical)	18		
	×	Disabled (Other)			
×	**Aged or Disabled, or Both - Specific Recognized Subgroups**				
	×	Brain Injury			×
	×	HIV/AIDS			×
	×	Medically Fragile			×
	×	Technology Dependent			×
×	**Intellectual Disability or Developmental Disability, or Both**				
	×	Autism			×
	×	Developmental Disability			×
	×	Mental Retardation			×
×	**Mental Illness** *(check each that applies)*				
	×	Mental Illness			×
	×	Serious Emotional Disturbance			

b. Additional Criteria. The State further specifies its target group(s) as follows:

The individual must:

1) Have established programmatic eligibility through the Utah Department of Human Services for state matching funds in accordance with Utah Code Annotated (UCA) § 62A-51 and Utah Administrative Code (UAC) R539-1-6 by meeting the following criteria:

a) Have at least one personal attendant trained (or willing to be trained) and available to provide the authorized PD Waiver services in a residence that is safe and can accommodate the personnel and equipment (if any) needed to adequately and safely care for the individual. DSPD will provide information to the individual about potential community resources to assist them in recruiting an attendant.

b) Be medically stable, have a physical disability which the physician expects to last for a continuous period of not less than 12 months and which has resulted in the individual's functional loss of two or more limbs.

c) Have decision making capability to select, train and supervise their personal attendant(s) as certified by a physician.

d) Have decision making capability to manage their own financial and legal affairs.

2) If a person is eligible for more than one of the waivers operated by DSPD, DSPD will educate the individual about their choices and advise them which of the waivers may best meet their needs.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one)*:

✦	Not applicable.There is no maximum age limit
X	The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit. *Specify*:
	Clients age from the Disabled (Physical) to the Aged (age 65 and older) target group/subgroup.

Appendix B-2: Individual Cost Limit

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one).* Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

X	**No Cost Limit**. The State does not apply an individual cost limit. *Do not complete Item B-2-b or Item B-2-c*.
✦	**Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c*. The limit specified by the State is *(select one)*:
✦	**%** — A level higher than 100% of the institutional average Specify the percentage:
✦	Other *(specify)*:
✦	**Institutional Cost Limit**. Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c*.
✦	**Cost Limit Lower Than Institutional Costs**. The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver. *Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.*
	The cost limit specified by the State is *(select one)*:
✦	**The following dollar amount**: Specify dollar amount:
	The dollar amount *(select one)*:
✦	**Is adjusted each year that the waiver is in effect by applying the following formula:** Specify the formula:
✦	**May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**
✦	**The following percentage that is less than 100% of the institutional**

State:	
Effective Date	

		average:		
	✦	**Other:** *Specify:*		

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

×	**The participant is referred to another waiver that can accommodate the individual's needs.**
×	**Additional services in excess of the individual cost limit may be authorized.** Specify the procedures for authorizing additional services, including the amount that may be authorized:
×	**Other safeguard(s)** *(Specify)*:

Appendix B-3: Number of Individuals Served

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a	
Waiver Year	**Unduplicated Number of Participants**
Year 1	105
Year 2	105
Year 3	105
Year 4 (only appears if applicable based on Item 1-C)	105
Year 5 (only appears if applicable based on Item 1-C)	105

✦	**The State does not limit the number of participants that it serves at any point in time during a waiver year.**
X	**The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table B-3-b	
Waiver Year	**Maximum Number of Participants Served At Any Point During the Year**
Year 1	**90**
Year 2	**90**
Year 3	**90**

State:	
Effective Date	

Year 4 (only appears if applicable based on Item 1-C)	**90**
Year 5 (only appears if applicable based on Item 1-C)	**90**

c. Reserved Waiver Capacity. The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

X	**Not applicable**. **The state does not reserve capacity.**
✦	**The State reserves capacity for the following purpose(s).** Purpose(s) the State reserves capacity for:

Table B-3-c

Waiver Year	**Purpose** (provide a title or short description to use for lookup):	**Purpose** (provide a title or short description to use for lookup):
	Purpose (describe):	**Purpose** (describe):
	Describe how the amount of reserved capacity was determined:	**Describe how the amount of reserved capacity was determined:**
Waiver Year	**Capacity Reserved**	**Capacity Reserved**
Year 1		
Year 2		
Year 3		
Year 4 (only if applicable based on Item 1-C)		
Year 5 (only if applicable based on Item 1-C)		

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one):*

X	**The waiver is not subject to a phase-in or a phase-out schedule.**

State:	
Effective Date	

✦	**The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an *intra-year* limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

X	**Waiver capacity is allocated/managed on a statewide basis.**
✦	**Waiver capacity is allocated to local/regional non-state entities. Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:**

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

Medicaid recipients who meet the programmatic eligibility requirements as defined in Appendix B-1 are given a choice to either receive services in a Nursing Facility (NF) or through the PD Waiver. The applicant's choice will be documented in writing, signed by the applicant and maintained as part of the individual record in the Utah Systems for Tracking Eligibility, Planning and Services (USTEPS).

If available capacity exists, individuals may enroll in the PD Waiver. If no available capacity exists in the PD Waiver, the applicant will be advised in writing that he or she may access services through a NF or may wait for open capacity to develop in the PD Waiver. If the individual chooses to wait for open capacity, DSPD provides information about community resources to assist the individual. In addition, if the individual is currently Medicaid eligible, they have access to Medicaid State Plan services.

The State has developed policies prioritizing access to individuals waiting for waiver services. These policies provide opportunities for access to individuals residing in the community and in institutional settings.

DSPD has established a needs assessment process by which individuals are ranked to prioritize access to waiver services. A significant component of the Needs Assessment Questionnaire addresses the immediacy of the need for services and the individual's risk in not gaining access to waiver services.

The State initiated a separate process in which individuals in institutional settings may gain access to waiver services. Medicaid recipients residing in nursing facilities, meeting the PD Waiver criteria may gain access to the PD Waiver by having the State general funds, that supported the person in the NF, follow the person into the PD Waiver, i.e., the money-follows-the-person concept.

The State believes the existence of these two access points of admission into the PD Waiver is an equitable methodology to support access from both the institution and the community. This methodology is supported by the State's Olmstead Advisory Committee and has not resulted in growth of the NF program. The State has chosen to not reserve capacity to accommodate both points of entry.

The individual tracks do not take priority over each other as each track has its own funding process. Once a person in institutional care (i.e., NF) is ready to transition from the NF and is found eligible to receive services through the PD Waiver, as long as the number of unduplicated participants authorized in the waiver has not been exceeded, the person may begin receiving services.

A person who lives in the community with physical disabilities and who has an immediate need for services is placed on the waiting list. Once the Utah State Legislature provides an allocation, those waiting with the greatest criticality receive funding first until the allocation is expended.

State:	
Effective Date	

B-3: Number of Individuals Served - Attachment #1

Waiver Phase-In/Phase Out Schedule

Based on Waiver Proposed Effective Date:

a. The waiver is being *(select one)*:

✦	Phased-in
✦	Phased-out

b. **Phase-In/Phase-Out Time Schedule.** Complete the following table:

Beginning (base) number of Participants:

Phase-In or Phase-Out Schedule			
	Waiver Year:		
Month	**Base Number of Participants**	**Change in Number of Participants**	**Participant Limit**

c. **Waiver Years Subject to Phase-In/Phase-Out Schedule** *(check each that applies)*:

Year One	Year Two	Year Three	Year Four	Your Five
×	×	×	×	×

State:	
Effective Date	

d. Phase-In/Phase-Out Time Period. *Complete the following table:*

	Month	Waiver Year
Waiver Year: First Calendar Month		
Phase-in/Phase out begins		
Phase-in/Phase out ends		

State:	
Effective Date	

Appendix B-4: Medicaid Eligibility Groups Served in the Waiver

a. 1. State Classification. The State is a *(select one)*:

✦	§1634 State
X	SSI Criteria State
✦	209(b) State

2. Miller Trust State.

Indicate whether the State is a Miller Trust State *(select one).*

X	No
✦	Yes

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply:*

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)				
×	Low income families with children as provided in §1931 of the Act			
X	SSI recipients			
×	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121			
X	Optional State supplement recipients			
X	Optional categorically needy aged and/or disabled individuals who have income at: *(select one)*			
	X	100% of the Federal poverty level (FPL)		
	✦	%	of FPL, which is lower than 100% of FPL Specify percentage:	
X	Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)			
×	Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)			
×	Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)			
×	Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)			
×	Medically needy in 209(b) States (42 CFR §435.330)			
X	Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)			
×	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:			

State:	
Effective Date	

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

✦	**No**. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.
X	**Yes**. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. *Select one and complete Appendix B-5.*

	✦	All individuals in the special home and community-based waiver group under 42 CFR §435.217				
	X	Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217 *(check each that applies)*:				
		X	A special income level equal to (select one):			
			X	300% of the SSI Federal Benefit Rate (FBR)		
			✦	%	A percentage of FBR, which is lower than 300% (42 CFR §435.236) Specify percentage:	
			✦	$	A dollar amount which is lower than 300% Specify percentage:	
		×	Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)			
		×	Medically needy without spend down in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)			
		×	Medically needy without spend down in 209(b) States (42 CFR §435.330)			
		×	Aged and disabled individuals who have income at: *(select one)*			
			✦	100% of FPL		
			✦	%	of FPL, which is lower than 100%	
		×	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:			

Appendix B-5: Post-Eligibility Treatment of Income

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 *(select one)*:

X	Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State elects to (*select one*):
	X — Use *spousal* post-eligibility rules under §1924 of the Act. *Complete ItemsB-5-b (SSI State) and Item B-5-d.*
	✦ — Use *regular* post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State) (*Complete Item B-5-b (SSI State). Do not complete Item B-5-d)*
✦	Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse. (*Complete Item B-5-b (SSI State). Do not complete Item B-5-d)*

b. Regular Post-Eligibility Treatment of Income: SSI State. The State uses the post-eligibility rules at 42 CFR §435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):				
X	The following standard included under the State plan *(Select one):*			
	✦	**SSI standard**		
	✦	**Optional State supplement standard**		
	✦	**Medically needy income standard**		
	X	**The special income level for institutionalized persons** *(select one):*		
		X	**300% of the SSI Federal Benefit Rate (FBR)**	
		✦	%	**A percentage of the FBR, which is less than 300%** Specify the percentage:
		✦	$	**A dollar amount which is less than 300%.** Specify dollar amount:
	✦	%		A percentage of the Federal poverty level Specify percentage:
	✦	**Other standard included under the State Plan** Specify:		
✦	**The following dollar amount**	$		If this amount changes, this item will be revised.

State:	
Effective Date	

	Specify dollar amount:		
✦	**The following formula is used to determine the needs allowance:** Specify:		
✦	Other Specify:		

ii. Allowance for the spouse only (*select one*):

X	**Not Applicable**
✦	**The State provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:** *Specify:*

Specify the amount of the allowance (*select one*):

✦	**SSI standard**		
✦	**Optional State supplement standard**		
✦	**Medically needy income standard**		
✦	**The following dollar amount:** Specify dollar amount:	$	If this amount changes, this item will be revised.
✦	**The amount is determined using the following formula:** *Specify:*		

iii. Allowance for the family *(select one)*:

X	**Not Applicable *(see instructions)***		
✦	**AFDC need standard**		
✦	**Medically needy income standard**		
✦	**The following dollar amount:** Specify dollar amount:	$	The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
✦	**The amount is determined using the following formula:** *Specify:*		
✦	Other		

State:	
Effective Date	

	Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

X	**Not applicable *(see instructions)*** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
✦	**The State does not establish reasonable limits.**
✦	**The State establishes the following reasonable limits** *Specify*:

c. Regular Post-Eligibility Treatment of Income: 209(B) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- ✦ The following standard included under the State plan *(select one)*
  - ✦ The following standard under 42 CFR §435.121
    Specify:
  - ✦ Optional State supplement standard
  - ✦ Medically needy income standard
  - ✦ The special income level for institutionalized persons *(select one):*
    - ✦ 300% of the SSI Federal Benefit Rate (FBR)
    - ✦ % — A percentage of the FBR, which is less than 300%
      Specify percentage:
    - ✦ $ — A dollar amount which is less than 300% of the FBR
      Specify dollar amount:
  - ✦ % — A percentage of the Federal poverty level
    Specify percentage:
  - ✦ Other standard included under the State Plan (specify):
- ✦ The following dollar amount: $ — Specify dollar amount: If this amount changes, this item will be revised.
- ✦ The following formula is used to determine the needs allowance
  Specify:
- ✦ Other (specify)

ii. Allowance for the spouse only (*select one*):

- ✦ Not Applicable (see instructions)
- ✦ The following standard under 42 CFR §435.121
  Specify:
- ✦ Optional State supplement standard

State:	
Effective Date	

✦	Medically needy income standard		
✦	The following dollar amount: Specify dollar amount:	$	If this amount changes, this item will be revised.
✦	The amount is determined using the following formula: *Specify:*		

iii. Allowance for the family *(select one)*

✦	Not applicable *(see instructions)*		
✦	AFDC need standard		
✦	Medically needy income standard		
✦	The following dollar amount: Specify dollar amount: of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.	$	The amount specified cannot exceed the higher
✦	The amount is determined using the following formula: *Specify:*		
✦	Other (specify):		

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.735:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

✦	Not applicable *(see instructions) Note: If the State protects the maximum amount for the waiver participant, not applicable must be checked.*
✦	The State does not establish reasonable limits.
✦	The State establishes the following reasonable limits *(specify)*:

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan.. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

*(select one)***:**

✦	**SSI Standard**		
✦	**Optional State supplement standard**		
✦	**Medically needy income standard**		
X	**The special income level for institutionalized persons**		
✦	%	Specify percentage:	
✦	**The following dollar amount:**	$	If this amount changes, this item will be revised
✦	**The following formula is used to determine the needs allowance:** *Specify formula:*		
✦	**Other** *Specify***:**		

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

X	**Allowance is the same**
✦	**Allowance is different.** *Explanation of difference:*

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

X	**Not applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
✦	**The State does not establish reasonable limits.**

✦	**The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

e. Regular Post-Eligibility Treatment of Income: SSI State - 2014 through 2018

The State uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. <u>Allowance for the needs of the waiver participant</u> (*select one*):					
✦	The following standard included under the State plan *(select one)*				
	✦	SSI standard			
	✦	Optional State supplement standard			
	✦	Medically needy income standard			
	✦	The special income level for institutionalized persons *(select one):*			
		✦	300% of the SSI Federal Benefit Rate (FBR)		
		✦	%	A percent of the FBR, which is less than 300%	
		✦	$	A dollar amount which is less than 300%.	
	✦	%	A percentage of the Federal poverty level		
	✦	Other standard included under the State Plan (specify):			
✦	The following dollar amount Specify dollar amount:	$	If this amount changes, this item will be revised.		
✦	The following formula is used to determine the needs allowance: *Specify:*				
✦	Other (specify):				
ii. <u>Allowance for the spouse only</u> (*select one*):					
✦	Not Applicable				
✦	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided: *Specify:*				
	Specify the amount of the allowance:				
	✦	SSI standard			
	✦	Optional State supplement standard			
	✦	Medically needy income standard			
	✦	The following dollar amount: Specify dollar amount:	$	If this amount changes, this item will be revised.	
	✦	The amount is determined using the following formula:			

State:	
Effective Date	

		Specify:

iii. Allowance for the family *(select one)*:

✦	Not applicable (see instructions)
✦	AFDC need standard
✦	Medically needy income standard
✦	The following dollar amount: $ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised. Specify dollar amount:
✦	The amount is determined using the following formula: *Specify:*
✦	Other *(specify)*:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

✦	Not applicable *(see instructions) Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
✦	The State does not establish reasonable limits.
✦	The State establishes the following reasonable limits *(specify)*:

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018

i. Allowance for the needs of the waiver participant (*select one*):

✦		The following standard included under the State plan *(select one)*
	✦	The following standard under 42 CFR §435.121 *Specify*:
	✦	Optional State supplement standard

State:	
Effective Date	

✦	Medically needy income standard			
✦	The special income level for institutionalized persons *(select one)*			
✦	300% of the SSI Federal Benefit Rate (FBR)			
✦	%	A percentage of the FBR, which is less than 300%		
✦	$	A dollar amount which is less than 300% of the FBR		
✦	%	A percentage of the Federal poverty level		
✦	Other standard included under the State Plan (specify):			
✦	The following dollar amount Specify dollar amount:	$	If this amount changes, this item will be revised.	
✦	The following formula is used to determine the needs allowance: *Specify:*			
✦	Other (*specify):*			

ii. <u>Allowance for the spouse only</u> (*select one*):

✦	Not applicable			
✦	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided: *Specify:*			
	Specify the amount of the allowance:			
✦	The following standard under 42 CFR §435.121: *Specfiy:*			
✦	Optional State supplement standard			
✦	Medically needy income standard			
✦	The following dollar amount: Specify dollar amount:	$	If this amount changes, this item will be revised.	
✦	The amount is determined using the following formula: *Specify*			

iii. <u>Allowance for the family</u> *(select one)*

	Not applicable (see instructions)

State:	
Effective Date	

✦	AFDC need standard
✦	Medically needy income standard
✦	The following dollar amount: Specify dollar amount: $ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
✦	The amount is determined using the following formula:
✦	Other (specify):

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR 435.735:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

✦	Not applicable *(see instructions) Note: If the State protects the maximum amount for the waiver participant, not applicable must be checked.*
✦	The State does not establish reasonable limits.
✦	The State establishes the following reasonable limits *(specify)*:

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

*(select one)***:**

✦	**SSI Standard**		
✦	**Optional State supplement standard**		
✦	**Medically needy income standard**		
✦	**The special income level for institutionalized persons**		
✦	%	Specify percentage:	
✦	**The following dollar amount:**	$	If this amount changes, this item will be revised
✦	**The following formula is used to determine the needs allowance:** *Specify formula:*		
✦	**Other** *Specify***:**		

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

✦	**Allowance is the same**
✦	**Allowance is different.** *Explanation of difference:*

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

✦	**Not applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
✦	**The State does not establish reasonable limits.**
✦	**The State uses the same reasonable limits as are used for regular (non-spousal) post-**

	eligibility.

State:	
Effective Date	

State:	
Effective Date	

Appendix B-6: Evaluation / Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for waiver services:

i.	**Minimum number of services**. The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is*:* 1	
ii.	**Frequency of services**. The State requires (select one):	
	X	**The provision of waiver services at least monthly**
	✦	**Monthly monitoring of the individual when services are furnished on a less than monthly basis** If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

✦	**Directly by the Medicaid agency**
X	**By the operating agency specified in Appendix A**
✦	**By an entity under contract with the Medicaid agency.** *Specify the entity*:
✦	**Other** *Specify*:

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Individuals performing initial level of care evaluations will be Utah licensed registered nurses employed by DSPD.

State:	
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d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

Utah Administrative Code R414-502 defines the State's level of care for NF care. The rule defines that a client must meet two of the following three criteria (specifically criteria 1 and 3 below for participants of the PD Waiver):

(1) Due to diagnosed medical conditions, the applicant requires substantial physical assistance with daily living activities above the level of verbal prompting, supervising, or setting up;

(2) The attending physician has determined that the applicant's level of dysfunction in orientation to person, place, or time requires nursing facility care; or equivalent care provided through a Medicaid Home and Community- Based Waiver program; or

(3) The medical condition and intensity of services indicate that the care needs of the applicant cannot be safely met in a less structured setting, or without the services and supports of a Medicaid Home and Community- Based Waiver program.

DSPD will conduct evaluation and reevaluation assessments using the standard waiver instrument, InterRAI MINIMUM DATA SET – HOME CARE (MDS-HC) as described in Appendix B-6(e), to assess level of care.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

✦	**The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
X	**A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.** Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.
	The InterRAI MINIMUM DATA SET - HOME CARE (MDS-HC) is the instrument used to determine the level of care for this waiver. Persons responsible for collecting the needed information and for making level of care determinations are staff from DSPD trained in the proper application of the MDS-HC instrument and the proper analysis of the MDS-HC data to perform level of care evaluations. The MDS-HC is a comprehensive, standardized instrument for evaluating the needs, strengths and preferences of clients served by home care agencies. The MDS-HC also acts as a screening component that enables a home care provider to assess multiple key domains of function, health, social support and service use. Particular MDS-HC items identify clients who could benefit from further evaluation of specific problems and risk for functional decline. The MDS-HC has been designed to be compatible with the family of InterRAI assessment and problem identification tools which includes the MDS (InterRAI Minimum Data Set) nursing home assessment instrument. Such compatibility promotes continuity of care through a

	seamless geriatric assessment system across multiple health care settings and promotes a person-centered evaluation in contradiction to a site-specific assessment. Accordingly, the main differences between the MDS-HC and the MDS is that the MDS includes assessment information more pertinent to a residential facility setting, addressing structural problems related to performance of ADLs (Activities of Daily Living) in a facility, activity pursuit patterns, discharge potential and overall status and therapy supplement. Whereas the MDS-HC includes assessment information more pertinent to community living by addressing social functioning, informal support services, preventative health measures, environmental assessment, service utilization of home care services, medications (prescription, non-prescription and herbal), resource/support and services assessment and information, social resource assessment, caregiver assessment, social support information, additional medical problems and nurse summary sections. Despite these differences, both the MDS-HC and MDS assessments help to determine level of care by including basic assessment data related to the individual. This information includes: identification and background information, cognitive patterns, communication/hearing patterns, vision patterns, mood and behavior patterns, physical functioning [Instrumental Activities of Daily Living (IADLs) and ADLs performance], continence, disease diagnoses, health conditions, nutrition/hydration status, skin condition, special treatments and therapies and programs.

f. Process for Level of Care Evaluation/Reevaluation. Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

DSPD utilizes the following process to make level of care determinations as follows:

The registered nurse employed by DSPD will conduct a face to face level of care assessment using the standard waiver instrument described in Appendix B-6(e). This assessment is conducted at the individual's current living environment.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

✦	**Every three months**
✦	**Every six months**
✦	**Every twelve months**
X	**Other schedule** *Specify* the other schedule:
	A full level of care reevaluation will be completed at a minimum of annually (no later than by the end of the calendar month of the last level of care evaluation, one year later). A Health Status Screening must be performed (either by phone or in person) by the administrative case manager at any time a participant has experienced a significant change in health status and at the conclusion of all inpatient stays in a medical institution to determine whether the participant's health status indicates that:

	1) The participant's needs can continue to be safely met within the scope of the PD Waiver program; and 2) The participant continues to meet NF level of care. If during the Health Status Screening it becomes evident that the participant's mental or physical condition has changed significantly, a new level of care reevaluation must be performed in person. The administrative case manager will document the Health Status Screening date and determination in the participant's activity log in USTEPS.

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

X	**The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
✦	**The qualifications are different.** *Specify the qualifications:*

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify)*:

USTEPS, developed and maintained by DSPD, creates an automated tickler "to do" message that is sent at the beginning of the month in which a reevaluation is due.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Electronically retrievable documentation of all evaluations and reevaluations are maintained within the USTEPS system for a minimum of three years as required.

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: **Level of Care Assurance/Sub-assurances**

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.

State:	
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For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

<table>
<tr><td>Performance Measure: #1</td><td colspan="3">Number and percentage of individuals who had a level of care evaluation completed, within 45 days of submitting a completed intake packet, when seeking waiver services. Numerator is the number of LOC reviews completed within the required time frame; Denominator is the number of individuals requiring review.</td></tr>
<tr><td>Data Source
● USTEPS</td><td>Responsible Party for data collection/generation (check each that applies)</td><td>Frequency of data collection/generation: (check each that applies)</td><td>Sampling Approach (check each that applies)</td></tr>
<tr><td></td><td>☐ State Medicaid Agency</td><td>☐ Weekly</td><td>X 100% Review</td></tr>
<tr><td></td><td>X Operating Agency</td><td>☐ Monthly</td><td>☐ Less than 100% Review</td></tr>
<tr><td></td><td>☐ Sub-State Entity</td><td>☐ Quarterly</td><td>☐ Representative Sample;</td></tr>
<tr><td></td><td>☐ Other: Specify:</td><td>☐ Annually</td><td></td></tr>
<tr><td></td><td></td><td>X Continuously and Ongoing</td><td>☐ Stratified: Describe Groups</td></tr>
<tr><td></td><td></td><td>☐ Other: Specify:</td><td></td></tr>
<tr><td></td><td></td><td></td><td>☐ Other: Describe</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td>Data Aggregation and Analysis</td><td>Responsible Party for data aggregation and analysis (check each that applies</td><td>Frequency of data aggregation and analysis: (check each that applies</td><td></td></tr>
<tr><td></td><td>☐ State Medicaid Agency</td><td>☐ Weekly</td><td></td></tr>
<tr><td></td><td>X Operating Agency</td><td>☐ Monthly</td><td></td></tr>
</table>

State:	
Effective Date	

	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	*X Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

ii. Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

***Performance Measure:* #1**	*Number and percentage of initial level of care determinations completed correctly using the assessments/tools stated in the waiver. Numerator is the number of correct LOC determinations; Denominator is the total number of LOC determinations performed.*		
Data Source • **USTEPS**	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	✗ *State Medicaid Agency*	✗ *Weekly*	✗ *100% Review*
	X *Operating Agency*	✗ *Monthly*	**X** *Less than 100% Review*
	✗ *Sub-State Entity*	✗ *Quarterly*	**X** *Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error*
	✗ *Other: Specify:*	✗ *Annually*	
		X Continuously and Ongoing	✗ *Stratified: Describe Groups*
		Other: Specify:	
			✗ *Other: Describe*

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			DSPD:
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	✗ *State Medicaid Agency*	✗ *Weekly*	
	X *Operating Agency*	✗ *Monthly*	
	✗ *Sub-State Entity*	✗ *Quarterly*	
	✗ *Other: Specify:*	*X Annually*	
		✗ *Continuously and Ongoing*	
		Other: Specify:	

***Performance Measure:* #3**	**Number and percentage of LOC initial evaluations conducted by a licensed Utah Registered Nurse (RN).** The numerator is the number of LOC initial evaluations which were performed by a licensed Utah RN; the denominator is the total number of LOC initial evaluations performed and reviewed.		
Data Source ● **USTEPS**	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	✗ *State Medicaid Agency*	✗ *Weekly*	*X 100% Review*
	X *Operating Agency*	✗ *Monthly*	*Less than 100% Review*
	✗ *Sub-State Entity*	✗ *Quarterly*	*X Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error*
	✗ *Other: Specify:*	***X*** *Annually*	
		✗ *Continuously and Ongoing*	✗ *Stratified: Describe Groups*
		✗ *Other: Specify:*	
			✗ *Other: Describe* DSPD:
Data Aggregation and Analysis	***Responsible Party for data aggregation and***	***Frequency of data aggregation and***	

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	analysis *(check each that applies*	***analysis:*** *(check each that applies*	
	✗ *State Medicaid Agency*	✗ *Weekly*	
	X *Operating Agency*	✗ *Monthly*	
	✗ *Sub-State Entity*	✗ *Quarterly*	
	✗ *Other: Specify:*	***X*** *Annually*	
		✗ *Continuously and Ongoing*	
		✗ *Other: Specify:*	

i. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

Individuals who request services from DSPD through the PD Waiver are screened for level of care and then ranked according to a critical needs assessment process and placed on the waiting list. When the individual is taken off of the waiting list, the administrative case manager determines if the individual needs services from the PD Waiver program. For all individuals who have been taken off of the waiting list and require services, an evaluation for level of care is conducted by the administrative case manager. DSPD is the entity that will conduct level of care reviews. Issues regarding the accuracy of level of care determinations are addressed and corrected immediately by DSPD.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.*

Individual issues regarding the accuracy of level of care determination are addressed and corrected immediately by DSPD to assure that all participants meet NF level of care. Plans of correction which include additional training may be required to assure future compliance. To assure all issues have been addressed, DSPD is required to report back to the SMA on the results of their interventions within the time frame stipulated in standard operating procedures and protocols or are stipulated on a case by case basis depending on the nature of a specific issue. Results of the reviews will be documented in the SMA Final Report.

ii. Remediation Data Aggregation

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Remediation-related Data Aggregation and Analysis (including trend identification)	***Responsible Party*** *(check each that applies)*	***Frequency of data aggregation and analysis:*** *(check each that applies)*
	X *State Medicaid Agency*	✗ *Weekly*
	X *Operating Agency*	✗ *Monthly*
	✗ *Sub-State Entity*	✗ *Quarterly*
	✗ *Other: Specify:*	*X Annually*
		✗ *Continuously and Ongoing*
		✗ *Other: Specify:*

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

✦	**Yes** *(complete remainder of item)*
X	**No**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B-6: 10

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Appendix B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and

ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Freedom of Choice is documented in the Person Centered Support Plan (PCSP).

Freedom of choice procedures:

1. When an individual is determined eligible for waiver services, the individual and the individual's representative, if applicable, will be informed of the alternatives available under the waiver programs and offered the choice of institutional care (NF) or home and community-based care. A copy of the DSPD publication AN INTRODUCTORY GUIDE-Division of Services for People with Disabilities (Guide), which describes the array of services and supports available in Utah including NFs and the HCBS waiver programs, is given to each individual applying for waiver services.

2. The administrative case manager will offer the choice of waiver services only if:
   a. The individual's needs assessment indicates the services the individual requires, including waiver services, are available in the community.
   b. The individual support plan has been agreed to by all parties.
   c. The health and safety of the individual can be adequately protected in relation to the delivery of waiver services and supports.

3. Once the individual has chosen home and community-based waiver services, the choice has been documented by the administrative case manager and the individual has received a copy of the Guide, subsequent review of choice of program will only be required at the time a substantial change in the enrollee's condition results in a change in the PCSP. It is, however, the individual's option to choose institutional (NF) care at any time during the period they are in the waiver.

4. The waiver enrollee will be given the opportunity to choose the providers of waiver services identified on the PCSP if more than one qualified provider is available to render the services. The individual's choice of providers will be documented in the PCSP.

5. The agency will provide an opportunity for a fair hearing in writing, under 42 CFR Part 431, subpart E, to beneficiaries who are not given the choice of home or community-based services as an alternative to the institutional care specified for this request, who are denied the waiver service(s) and/or waiver provider(s) of their choice, who are found ineligible for a waiver program or who have been notified of actions to suspend, reduce and/or terminate services.

b. Maintenance of Forms. Per 45 CFR § 92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

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The Operating Agency maintains the Freedom of Choice Form 818 electronically in USTEPS for a minimum of three years as required.

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Appendix B-8: Access to Services by Limited English Proficient Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

Medicaid providers are required to provide foreign language interpreters for Medicaid clients who have limited English proficiency. Waiver clients are entitled to the same access to an interpreter to assist in making appointments for qualified procedures and during those visits. Providers must notify clients that interpretive services are available at no charge. The SMA and OA encourage clients to use professional services rather than relying on a family member or friend though the final choice is theirs. Using an interpretive service provider ensures confidentiality as well as the quality of language translation. Waiver participants may be referred to Medicaid interpretive services by providers, their support coordinator, and/or State staff from the OA or SMA for covered State Plan services.

Information regarding access to Medicaid Translation Services is included in the Medicaid Member Guide distributed to all Utah Medicaid recipients. Eligible individuals may access translation services by calling the Medicaid Helpline.

For the full text of the Medicaid Member Guide, go to:
http://health.utah.gov/umb/forms/pdf/mg_w_cover.pdf

Additionally, the Division of Services for People with Disabilities provides contracted interpretive services for limited English proficiency persons throughout the waiver entrance process. State staff explore the individual's preference, if any, for a type of language assistance service.

Bilingual State staff support individuals directly when available and desired by the individual. When interpreting, State staff must meet the following requirements:

-Demonstrate proficiency in and ability to communicate information accurately in both English and in the other language and identify and employ the appropriate mode of interpreting (e.g., consecutive, simultaneous, summarization, or sight translation);

-To the extent necessary for communication between the recipient or its staff and the LEP person, have knowledge in both languages of any specialized terms or concepts peculiar to the recipient's program or activity and of any particularized vocabulary and phraseology used by the LEP person;

-Understand and follow confidentiality and impartiality rules to the same extent as the recipient employee for whom they are interpreting and/or to the extent their position requires;

-Understand and adhere to their role as interpreters without deviating into other roles--such as counselor or advisor--where such deviation would be inappropriate

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Appendix C: Participant Services

Appendix C-1/C-3: Summary of Services Covered and Services Specifications

C-1-a. Waiver Services Summary. Appendix C-3 sets forth the specifications for each service that is offered under this waiver. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Statutory Services *(check each that applies)*		
Service	Included	Alternate Service Title (if any)
Case Management	×	
Homemaker	×	
Home Health Aide	×	
Personal Care	X	Personal Attendant Services
Adult Day Health	×	
Habilitation	×	
Residential Habilitation	×	
Day Habilitation	×	
Prevocational Services	×	
Supported Employment	×	
Education	×	
Respite	×	
Day Treatment	×	
Partial Hospitalization	×	
Psychosocial Rehabilitation	×	
Clinic Services	×	
Live-in Caregiver (42 CFR §441.303(f)(8))	×	
Other Services *(select one)*		
✦	Not applicable	

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X	As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional services not specified in statute *(list each service by title)*:
a.	Personal Emergency Response System (purchase, testing, installation and service fees)
b.	Specialized Medical Equipment and Supplies - Monthly Fee
c.	Specialized Medical Equipment and Supplies - Purchase, Installation, Removal, Replacement and Repair
d.	Transportation Services (non-medical)

Extended State Plan Services *(select one)*

X	Not applicable
✦	The following extended State plan services are provided *(list each extended State plan service by service title)*:
a.	
b.	
c.	

Supports for Participant Direction *(check each that applies))*

X	The waiver provides for participant direction of services as specified in Appendix E. The waiver includes Information and Assistance in Support of Participant Direction, Financial Management Services or other supports for participant direction as waiver services.
X	The waiver provides for participant direction of services as specified in Appendix E. Some or all of the supports for participant direction are provided as administrative activities and are described in Appendix E.
✦	Not applicable

Support	Included	Alternate Service Title (if any)
Information and Assistance in Support of Participant Direction	×	
Financial Management Services	X	

Other Supports for Participant Direction *(list each support by service title)*:

a.	
b.	
c.	

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C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Personal Attendant Services	
Category 1:	Sub-Category 1:
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition (Scope)**:**

Personal Attendant Services are essential to help the waiver participant achieve maximum independence and may vary depending on the needs of the individual and their daily schedule. Services may include: (a) hands-on care consisting of both a non-skilled medical and non-medical supportive nature specific to the needs of a medically stable individual with physical disabilities. Such support may involve assistance to the participant in performing all Activities of Daily Living (ADLs) including: bathing, dressing (upper/lower body), toileting, transferring, maintaining continence, positioning while in bed, eating, personal hygiene and locomotion in and out of the home. Any skilled medical care and health maintenance required as part of the participant's ADLs may also be provided but only as permitted by State law and as certified by the participant's physician; (b) assistance with all Instrumental Activities of Daily Living (IADLs) to include housekeeping, chore services, meal preparation, grocery shopping, non-medical transportation, using the telephone and all other reasonable and necessary activities which are incidental to the performance of the participant's care may additionally be furnished as part of this service when agreed upon by the participant, personal attendant and the case manager, as outlined in the Person Centered Support Plan (PCSP). Payment to parents, step-parents or legal guardians can be made for personal attendant services deemed as extraordinary and as outlined in appendix C-2(e).

Personal Attendant Services are not duplicative of State plan Personal Care as those services do not allow for an option to self-direct care while the Physical Disabilities waiver requires it.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Limitations: Limits on the amount, frequency and/or duration are specified in the PCSP and based upon assessed need. Personal Attendant services are rendered in 15 minute units.

Transportation may not be billed for separately and is included in the rate paid.

The RN Case Manager will monitor the utilization of both services and verify their continued necessity.

There could be any number of examples why a person would utilize both state plan personal care and personal

attendant services through the waiver.

1. The personal care state plan service is a similar but not exactly the same service as the personal attendant services in the waiver. Personal care state plan service does not allow for some of the assistance with IADLs and it is limited to 60 hours per month. Many times a client will avail themselves of the state plan personal care up to the maximum of 60 hours per month to provide specific ADL cares and will use attendant care through the waiver as an adjunct to provide assistance with shopping and paying bills and other IADLS.

2. A combination of state plan (traditional home health agency) services and self-directed services are provided to best meet the person's needs and preferences. For example – you may have a client who uses state plan services during the weekdays, but then the client prefers to have a self-directed service worker on the weekends due to the ability to have more flexible scheduling. Or the person may be willing to have personal care state plan for some services, but may prefer to have bathing completed 3 times a week by a trusted sibling etc.

The state believes this type of flexibility is in line with the intent of person-centered planning that is focused on the needs, preferences and cultural sensitivity of the individual's circumstances. In all cases, the care plan indicates when both services are being used.

Service Delivery Method *(check each that applies)*:	X	Participant-directed as specified in Appendix E	×	Provider managed	
Specify whether the service may be provided by *(check each that applies):*	×	Legally Responsible Person	X	Relative	× Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)***:**	X	Individual. List types:	×	Agency. List the types of agencies:
	Qualified individual selected by the participant			

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Individual Personal Attendant		Home Health Aide Certificate of Completion (R432-700-22) OR OTHER STANDARD	Be at least 18 years of age; have a Social Security Number and provide verification of such; agree to have a Criminal Background Check; have the ability to read, understand and carry out written and verbal instructions, write simple clinical notes and record messages; be trained in First Aid, Abuse, Neglect, Exploitation prevention and reporting, Legal rights of persons with disabilities, Confidentiality, Knowledge of person supporting; be oriented and trained in all aspects of care to be provided to the participant including

			medical care and health maintenance; and be able to demonstrate competency in all areas of responsibility. * All providers receiving state funds appropriated to DSPD are required to enter into a state contract with the DSPD as a provider of services to persons with disabilities. The DSPD state contract is a document separate from the Medicaid Provider Agreement negotiated between each waiver provider and the SMA. A joint DSPD state contract/SMA Provider Agreement is in place for this service.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Personal Attendant	**Division of Services for People with Disabilities' waiver recipient**	**Prior to the delivery of Medicaid Personal Attendant Services**

Service Specification	
Personal Emergency Response Systems (PERS)	
Category 1:	Sub-Category 1:
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
Service Definition (Scope)**:**	
Personal Emergency Response Systems serve the purpose of enabling the individual who has the skills to live independently (with natural/waiver supports) to summon assistance in case of an emergency.	

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Personal Emergency Response Systems involve electronic devices of a type that allows the individual requiring such a system to rapidly secure assistance in the event of an emergency. The device may be any one of a number of such devices but must be connected to a signal response center that is staffed twenty-four hours a day, seven days a week, by trained professionals.

Elements of Personal Emergency Response Systems:

- Personal Emergency Response Systems (PERS) Response Center Service
  - Provides ongoing access to a signal response center that is staffed twenty-four hours per day, seven days a week by trained professionals responsible for securing assistance in the event of an emergency.

- Personal Emergency Response Systems (PERS) Purchase, Rental & Repair
  - Provides an electronic device of a type that allows the individual to summon assistance in an emergency. The device may be any one of a number of such devices but must be connected to a signal response center.

- Personal Emergency Response Systems (PERS) Installation, Testing & Removal
  - Provides installation, testing, and removal of the PERS electronic device by trained personnel.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Limitations: PERS services are limited to those individuals who live alone, live with others who are not capable of responding in an emergency or who are alone for significant parts of the day and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

Service Delivery Method *(check each that applies)*:	×	Participant-directed as specified in Appendix E	X	Provider managed	
Specify whether the service may be provided by *(check each that applies):*	×	Legally Responsible Person	×	Relative	×	Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)***:**	×	Individual. List types:	X	Agency. List the types of agencies:
				Personal Emergency Response System suppliers and response centers.

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Personal Emergency Response System suppliers and response centers	Current business license		Emergency Response System Supplier - FCC registration of equipment placed in the participant's home. Enrolled with DSPD as an authorized provider of services and supports to people with

			disabilities in accordance with 62A-5-103, UCA. Personal Emergency Response System Installer - Demonstrated ability to properly install and test specific equipment being handled. Personal Emergency Response Center - 24 hour per day operation, 7 days per week. All Providers - Medicaid provider enrolled to provide personal emergency response system services.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Personal Emergency Response Systems	**Division of Services for People with Disabilities**	**Upon initial enrollment and annually thereafter**

Service Specification	
Specialized Medical Equipment and Supplies – Purchase, Installation, Removal, Replacement and Repair	
Category 1:	Sub-Category 1:
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
Service Definition (Scope)**:**	

Specialized Medical Equipment and Supplies – Purchase, Installation, Removal, Replacement and Repair includes the purchase of automated medication dispensary devices as well as the installation, removal, replacement and repair of these devices. This service also covers the training of participants or caregivers in the operation and/or maintenance of the equipment.

Automated medication dispensary devices consist of timed alarmed monitoring systems that have the ability to store and dispense proper dosages of medications at scheduled times as prescribed by the participant's medical practitioner(s). Medication dispensary devices reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State plan and must be of direct medical or remedial benefit to the participant. Medication dispensary devices shall only be an option when more simple methods of medication reminders are determined to be ineffective by DSPD, must be specified in the participant's PCSP and must also meet applicable standards of manufacture, design and installation.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Limitations: Expenditures for specialized medical equipment and the supplies necessary to operate that equipment will be in accordance with DSPD's policy and all purchases will comply with State procurement requirements. Each item of specialized medical equipment and supplies necessary for the operation of that equipment must be approved prior to purchase by an administrative case manager based on a determination of medical necessity and a determination that the item is not available as a Medicaid State Plan service.

For children under the age of 21, services determined to be medically necessary under the EPSDT benefit are covered pursuant to Section 1905(a) of the Social Security Act.

Service Delivery Method *(check each that applies)*:	×	Participant-directed as specified in Appendix E	X	Provider managed

Specify whether the service may be provided by *(check each that applies):*	×	Legally Responsible Person	×	Relative	×	Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)***:**	×	Individual. List types:	X	Agency. List the types of agencies:
				Automated Medication Dispensary Equipment and Supply Suppliers

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Specialized Medical Equipment and Supplies Supplier Personal Attendant	Current business license		FCC registration of equipment placed in the participant's home. Enrolled with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

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			Enrolled as a Medicaid provider. Automated Medication Dispensary Device Installer - Demonstrated ability to properly install and test specific equipment being handled.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Specialized Medical Equipment and Supplies Supplier	**Division of Services for People with Disabilities**	**Annually**

Service Specification	
Specialized Medical Equipment and Supplies – Monthly Fee	
Category 1:	Sub-Category 1:
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition (Scope)**:**

Specialized Medical Equipment and Supplies - Monthly Fee includes periodic service (e.g., monthly) fees for ongoing support services and/or rental associated with automated medication dispensary devices. Automated medication dispensary devices consist of timed alarmed monitoring systems that have the ability to store and dispense proper dosages of medications at scheduled times as prescribed by the participant's medical practitioner(s).

Periodic service fees associated with medication dispensary devices that are reimbursed with waiver funds are in addition to any medical equipment fees furnished under the State plan and must be in association with

medication dispensary devices which provide a direct medical or remedial benefit to the participant. Additionally, periodic service fees associated with medication dispensary devices must be specified in the participant's PCSP

Specialized Medical Equipment and Supplies - Monthly Fee will not include the costs of maintenance and upkeep of equipment as this is covered under the Specialized Medical Equipment and Supplies – Purchase, Installation, Removal, Replacement and Repair service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Limitations: Expenditures for specialized medical equipment and the supplies necessary to operate that equipment will be in accordance with DSPD's policy and all purchases will comply with State procurement requirements. Each item of specialized medical equipment and supplies necessary for the operation of that equipment must be approved prior to purchase by an administrative case manager based on a determination of medical necessity and a determination that the item is not available as a Medicaid State Plan service.

The services under Specialized Medical Equipment/Supplies/Assistive Technology—Monthly Fee are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Service Delivery Method *(check each that applies)*:	×	Participant-directed as specified in Appendix E	X	Provider managed

Specify whether the service may be provided by *(check each that applies):*	×	Legally Responsible Person	×	Relative	×	Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)*:	×	Individual. List types:	X	Agency. List the types of agencies:
				Automated Medication Dispensary Equipment and Supply Suppliers

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Specialized Medical Equipment and Supplies Supplier	Current business license		FCC registration of equipment placed in the participant's home. Enrolled with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. Enrolled as a Medicaid provider.

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Specialized Medical Equipment and Supplies Supplier	**Division of Services for People with Disabilities**	**Annually**

Service Specification	
Financial Management Services	
Category 1:	Sub-Category 1:
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition (Scope)**:**

Financial Management Services are offered in support of the self-administered services delivery option. Services rendered under this definition include those to facilitate the employment of personal attendants or assistants by the participant or designated representative including:

a) Provider qualification verification;

b) Employer-related activities including federal, state, and local tax withholding/payments, unemployment compensation fees, wage settlements, fiscal accounting and expenditure reports;

c) Medicaid claims processing and reimbursement distribution, and

d) Providing monthly accounting and expense reports to the participant and to DSPD.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Financial Management Services are intended to provide payroll services to Home and Community-Based Services waiver participants who elect participant direction. This service is provided to those utilizing Self-Directed Services. This service does not provide persons with assistance in managing their personal funds or budgets and does not provide representative payee services.

Service Delivery Method *(check each that applies)*:	×	Participant-directed as specified in Appendix E	X	Provider managed

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Specify whether the service may be provided by *(check each that applies):*	×	Legally Responsible Person	×	Relative	×	Legal Guardian

Provider Specifications				
Provider Category(s) *(check one or both)*:	×	Individual. List types:	X	Agency. List the types of agencies:
				Licensed Public Accounting Agency

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Financial Management Services	Certified Public Accountant Sec 58-26A, UCA and R156-26A, UAC	Certified by the SMA as an authorized provider of services and supports	• Under State contract with the SMA as an authorized provider of services and supports. • Comply with all applicable State and local licensing, accrediting and certification requirements. • Understand the laws, rules and conditions that accompany the use of State and local resources and Medicaid resources. • Utilize accounting systems that operate effectively on a large scale as well as track individual budgets. • Utilize a claims processing system acceptable to the SMA. • Establish time lines for payments that meet individual needs within DOL standards. • Generate service management, and statistical information and reports as required by the Medicaid program. • Develop systems that are flexible in meeting the changing circumstances of the Medicaid program. • Provide needed training and technical assistance to participants, their representatives and others. • Document required Medicaid provider qualifications and enrollment requirements and maintain results in provider/employee file. • Act on behalf of the person receiving

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			supports and services for the purpose of payroll reporting. ● Develop and implement an effective payroll system that addresses all related tax obligations. ● Make related payments as approved in the person's budget, authorized by the administrative case manager. ● Generate payroll checks in a timely and accurate manner and in compliance with all Federal and State regulations pertaining to "domestic service" workers. ● Conduct background checks as required and maintain results in employee file. ● Process all employment records. ● Obtain authorization to represent the individual/person receiving supports. ● Prepare and distribute an application package of information that is clear and easy for the individuals hiring their own staff to understand and follow. ● Establish and maintain a record for each employee and process the employee employment application package and documentation. ● Utilize an accounting information system to invoice and receive Medicaid reimbursement funds. ● Utilize an accounting and information system to track and report the distribution of Medicaid reimbursement funds. ● Generate a detailed Medicaid reimbursement funds distribution report to the individual participant or representative semi-annually. ● Withhold, file and deposit FICA, FUTA and SUTA taxes in accordance with IRS, DOL and State rules. ● Generate and distribute IRS W-2's, Wage and Tax Statements and related documentation annually to all support workers who meet the statutory threshold earnings amounts during the

			tax year by January 31st. ● File and deposit Federal and State income taxes in accordance with IRS, State rules and regulations. ● Assure that employees are paid established unit rates in accordance with Federal and State Fair Labor Standards Acts (FLSA). ● Process all judgments, garnishments, tax levies or any related holds on an employee's funds as may be required by local, State or Federal laws. ● Distribute, collect and process all employee time sheets as summarized on payroll summary sheets completed by the person or his/her representative. ● Prepare employee payroll checks, at least monthly, sending them directly to the employees. ● Keep abreast of all laws and regulations relevant to the responsibilities it has undertaken with regard to the required Federal and State filings and the activities related to being a Fiscal/Employer Agent. ● Establish a customer service mechanism in order to respond to calls from individuals or their representative employers and workers regarding issues such as withholding and net payments, lost or late checks, reports and other documentation. ● Customer service representatives are able to communicate effectively in English and Spanish by voice and TTY with people who have a variety of disabilities. ● Have a Disaster Recovery Plan for restoring software and master files and hardware backup if management information systems are disabled so that payroll and invoice payment systems remain intact. ● Regularly file and perform accounting auditing to ensure system accuracy and compliance with general accounting

			practice.

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Financial Management Services	**Division of Medicaid and Health Financing, Bureau of Authorization and Community Based Services**	**Upon initial enrollment and annually thereafter**

Service Specification	
Service Type: Other Service - Transportation (non-medical)	
Category 1:	Sub-Category 1:
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition (Scope)**:**

Transportation Services provide waiver participants with the opportunity to access other waiver supports as necessary to encourage, to the greatest extent possible, an independent, productive and inclusive community life. Whenever possible, participants receiving waiver services are trained, assisted, and provided opportunities to use available transportation services offered through family, neighbors, friends or community agencies which can provide this service without charge. If these transportation options are not available or do not meet the needs of the waiver enrollee, waiver non-medical transportation becomes an option.

Transportation Supports are only provided as independent waiver services when transportation is not otherwise available as an element of another waiver service. The need for transportation must be documented as necessary to fulfill other identified supports in the individual support plan and the associated outcomes.

During audit, the OA monitors for the billing of Transportation Services and validates that the trips met criteria to be billed as supplemental services. Elements of Transportation Services: The Transportation Services category consists of elements for a multi-pass for the public transit system.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Limitations: Medicaid payment for transportation under the approved waiver plan is not available for medical transportation. Medical transportation is defined as transportation covered by the State Plan that transports individuals to medical services that are covered by the State Plan. In addition, Medicaid payment is not available for any other transportation available through the State plan, transportation that is available at no charge, or as part of administrative expenditures.

Service Delivery Method *(check each that applies)*:	×	Participant-directed as specified in Appendix E	X	Provider managed (By UTA	

Specify whether the service may be provided by *(check each that applies):*	×	Legally Responsible Person	X	Relative	×	Legal Guardian	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	×	Individual. List types:	X	Agency. List the types of agencies:
	Qualified individual selected by the participant		Utah Transit Authority (UTA)	

Provider Qualifications			
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

✦		**Not applicable** – Case management is not furnished as a distinct activity to waiver participants.
X		**Applicable** – Case management is furnished as a distinct activity to waiver participants. Check each that applies:
	×	As a waiver service defined in Appendix C-3 (*do not complete C-1-c)*

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	×	As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option). *Complete item C-1-c.*
	×	As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). *Complete item C-1-c.*
	X	As an administrative activity. *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Administrative case managers employed by DSPD.

Appendix C-2: General Service Specifications

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services *(select one)*:

X	**Yes**. Criminal history and/or background investigations are required. Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):
	UCA 62A-2-120 and R501-14, of the Utah Human Services Administration, require all persons associated with a DHS licensee or a DHS contract having direct access to children or vulnerable adults to undergo a criminal history/background investigation. The Office of Licensing, an agency within the Utah Department of Human Services, has the responsibility of conducting background checks on all direct care workers who provide waiver services. The scope of the investigation includes a check of the State's child and adult abuse registries (maintained by The Utah Division of Child and Family Services and The Utah Division of Aging and Adult Services respectively), and a Criminal History check through the Criminal Investigations and Technical Services Division of the Department of Public Safety. If a person provides care in a congregate care facility and has lived outside the State of Utah six or more consecutive weeks within the last five years, the FBI National Criminal History Records and National Criminal History will be accessed to conduct a check in those states where the person resided. The Division of Services for People with Disabilities (DSPD) maintains a database on all approved employees. DSPD will not approve payments if the required screenings have not been completed. For providers under the Self-Administered Service Model, the state will withhold payments for services for anyone who has not completed a background check within the first 30 days of being hired. The Division of Services for People with Disabilities (DSPD) has the ability to view the database of the Office of Licensing in regards to the status of employees hired under the self-administered model. All employees are required to renew their background checks on an annual basis. The health and safety of participants are ensured by routinely scheduled face-to-face visits by support coordinators and by quality monitoring reviews performed by DHS/DSPD and the SMA.
✦	**No**. Criminal history and/or background investigations are not required.

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry *(select one)*:

X	**Yes**. The State maintains an abuse registry and requires the screening of individuals through this registry. Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):
	Utah Code (Annotated) 62A-2-121, 122 and R501-14 of the Utah Administrative Code require all persons having direct access to children or vulnerable adults must undergo an abuse screening. The Utah Division of Aging and Adult Services and The Utah Division of Child and Family Services maintain these abuse registries. A designated staff person within DHS, Office of Licensing, completes all screenings. DSPD, through its contracted fiscal intermediaries, has access to all approved employees and will not approve continued employment or provider payments if the required screenings have not been completed in a timely fashion. The State uses contract reviews of providers (including Financial Management Services agencies for individuals using self-direction) to validate that mandatory abuse registry checks are completed. Validation of abuse registry checks may also occur during the review of critical incidents.
✦	**No**. The State does not conduct abuse registry screening.

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one*:

X	**No**. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act. *Do not complete Items C-2-c.i – c.iii.*
✦	**Yes**. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). *Complete Items C-2-c.i –c.iii.*

i. Types of Facilities Subject to §1616(e). Complete the following table for *each type* of facility subject to §1616(e) of the Act:

Type of Facility	Waiver Service(s) Provided in Facility	Facility Capacity Limit

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ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

iii. Scope of Facility Standards. For this facility type, please specify whether the State's standards address the following *(check each that applies)*:

Standard	Topic Addressed
Admission policies	×
Physical environment	×
Sanitation	×
Safety	×
Staff : resident ratios	×
Staff training and qualifications	×
Staff supervision	×
Resident rights	×
Medication administration	×
Use of restrictive interventions	×
Incident reporting	×
Provision of or arrangement for necessary health services	×

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

X	**No**. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.
✦	**Yes**. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services. Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

✦	**The State does not make payment to relatives/legal guardians for furnishing waiver services.**
X	**The State makes payment to relatives/legal guardians under *specific circumstances* and only when the relative/guardian is qualified to furnish services**. Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*
	The types of relatives to who payment is made: With the exception of parents, step-parents and legal guardians of adult children who are only allowed to be paid under specific circumstances, there are no restrictions to payments made to relatives of the participant. Specific circumstances under which payment is made to a parent, step-parent and/or legal guardian of the participant: 1. When a participant lives in a rural area within five miles of a population center of less than 2,500 and there are no other resources available to offer supports within a reasonable

	geographic area (15 miles) from the participant and the participant conducts an ongoing recruitment of resources other than a parent, step-parent and/or legal guardian; 2. When the parent, step-parent and/or legal guardian, who has specialized training for safely operating health related technology for the participant including but not limited to the operation of a ventilator, G peg tube feeding, home dialysis infusion and wound care, performs those tasks because the participant can demonstrate they have no other dependable or qualified resources available to do so; 3. When the participant is functionally quadriplegic and is dependent on others to perform health and safety related supports and other routine ADLs; and/or 4. When the participant needs supports critical to their health and safety during non-traditional work hours such as during the night. In all such instances, parent, step-parent and/or legal guardian may be paid to provide services under the PD Waiver through the Personal Attendant service. Controls that are employed to ensure that payments are made only for services rendered: In order for a parent, step-parent and/or legal guardian to be paid under this waiver, he/she must meet all of the following authorization criteria and monitoring provisions: - meet the criteria as outlined in the Personal Attendant Service; - the service must be specified in the participant's Person Centered Support Plan (PCSP); - service must be paid at a rate that does not exceed that which would otherwise be paid to an employee; and - time-sheets and other required documentation must be submitted for hours paid. Other monitoring requirements/provisions: The below listed requirements apply to participants electing to use parent, step-parent and/or legal guardian to be paid during specific circumstances: - monthly reviews by the FMS of hours billed for parents and/or step-parents care. These reviews will be overseen by the administrative case managers to ensure the appropriate usage and compliance with the billing process; - the administrative case manager will contact the participant by phone or e-mail on at least a quarterly basis to identify the proper usage of and compliance with the program and to also ensure the participant's health and safety as well as the status of the participant and if the specific circumstance still applies; and - the administrative case manager will conduct annual Self-Administered Services (SAS) reviews and will review all of the required SAS documentation.
✦	**Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.** Specify the controls that are employed to ensure that payments are made only for services rendered.

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✦	Other policy. *Specify*:

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f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

All Participants in the PD Waiver Program operated by DSPD are allowed to hire, train and supervise their own employees who provide direct care services.

Participants with physical disabilities hire staff in accordance with Federal IRS and DOL rules and regulations (IRS Revenue Ruling 87-41; IRS Publication 15-A: Employer's Supplemental Tax Guide; FLSA Domestic Service Regulations in 29 CFR § 552.3).

The Utah Department of Health will enter into a provider agreement with all willing providers who are selected by the participant and meet licensure, certification and/or other competency requirements.

DHS/DSPD provides a participant with choices for a fiscal agent. The fiscal agent is a private or public entity that is approved by the IRS (see IRS Revenue Procedure 70-6, 1970-1 C.B. 420) to act as the client's intermediary for the purpose of managing employment taxes, including income tax withholding, FICA, FUTA/SUTA, and brokering/managing benefits, including worker's compensation and state disability insurance premiums (if applicable). The fiscal agent collects employment documents and verifies signatures from participants prior to distributing paychecks to the participant's employees. The participant remains the employer of record, retaining control over the hiring, training, management and supervision of employees hired by the participant who provide direct care services.

The State continuously enrolls any willing and qualified providers. Agency-based providers may access information regarding requirements, procedures to provide services, and how to apply to become a provider through the OA site. A specific time frame is not established to process a provider's enrollment, but a provider may not begin performing service until all required elements of contracting are completed.

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: **Qualified Providers**

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

***Performance Measure:* #1**	**Number and percentage of PD Waiver providers who meet DSPD provider contract criteria.** The numerator is the number of PD Waiver providers that, upon initial enrollment and annually thereafter, met all DSPD contract criteria; the denominator is the total number of providers.		
Data Source ● **USTEPS**	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	✗ *State Medicaid Agency*	✗ *Weekly*	**X** *100% Review*
	X *Operating Agency*	✗ *Monthly*	✗ *Less than 100% Review*
	✗ *Sub-State Entity*	✗ *Quarterly*	✗ *Representative Sample; Confidence Interval =*
	✗ *Other: Specify:*	*X Annually*	
		✗ *Continuously and Ongoing*	✗ *Stratified: Describe Groups*
		Other: Specify:	

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			✗ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	✗ *State Medicaid Agency*	✗ *Weekly*	
	X *Operating Agency*	✗ *Monthly*	
	✗ *Sub-State Entity*	✗ *Quarterly*	
	✗ *Other: Specify:*	*X Annually*	
		✗ *Continuously and Ongoing*	
		Other: Specify:	

ii. Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

***Performance Measure:* #1**	**Number and percentage of PD Waiver participants who maintain accurate and updated Personal Attendant employee files in accordance with waiver requirements.** The numerator is the number of participants reviewed who are in compliance; the denominator is the total number of participants reviewed.		
Data Source • **Employee Files**	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	✗ *State Medicaid Agency*	✗ *Weekly*	✗ *100% Review*
	X *Operating Agency*	✗ *Monthly*	**X** *Less than 100% Review*

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	✗ *Sub-State Entity*	✗ *Quarterly*		**X** *Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error*
	✗ *Other: Specify:*	*X Annually*		
		✗ *Continuously and Ongoing*		✗ *Stratified: Describe Groups*
		Other: Specify:		
				✗ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*		
	✗ *State Medicaid Agency*	✗ *Weekly*		
	X *Operating Agency*	✗ *Monthly*		
	✗ *Sub-State Entity*	✗ *Quarterly*		
	✗ *Other: Specify:*	*X Annually*		
		✗ *Continuously and Ongoing*		
		Other: Specify:		

iii. Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

***Performance Measure:* #1**	**Number and percentage of PD Waiver participants who provided training to their Personal Attendant employees.** The numerator is the total number of participants who upon review are determined to have

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	trained their Personal Attendant employees; the denominator is the total number of participants reviewed.		
Data Source ● **USTEPS**	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	✗ *State Medicaid Agency*	✗ *Weekly*	✗ *100% Review*
	X *Operating Agency*	✗ *Monthly*	**X** *Less than 100% Review*
	✗ *Sub-State Entity*	✗ *Quarterly*	**X** *Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error*
	✗ *Other: Specify:*	*X Annually*	
		✗ *Continuously and Ongoing*	✗ *Stratified: Describe Groups*
		✗ *Other: Specify:*	
			✗ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	✗ *State Medicaid Agency*	✗ *Weekly*	
	X *Operating Agency*	✗ *Monthly*	
	✗ *Sub-State Entity*	✗ *Quarterly*	
	✗ *Other: Specify:*	*X Annually*	
		✗ *Continuously and Ongoing*	
		✗ *Other:Specify:*	

iv. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

DSPD contract analysts conduct annual provider reviews of all programs that provide services

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to PD waiver participants. Monitoring includes all criteria specified in the provider contract. Administrative case managers monitor a sample of SAS employees on a monthly basis. The administrative case managers also complete a review checklist which covers employee files, forms and appropriate training for staff. Time sheets are reviewed to ensure proper billing for services. Administrative case managers meet in person with the participant to confirm the employees have received appropriate training. Both the administrative case managers and the Utah Systems for Tracking Eligibility, Planning and Services (USTEPS) system track the expenditures for each participant and ensure that services remain within the allotted budget.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.*

Individual provider issues identified either through contract reviews or monitoring of SAS, conducted by administrative case managers, are corrected immediately or, at a minimum, within designated time frames. To assure all issues have been addressed, DSPD is required to report back to the SMA on the results of their interventions within the time frame stipulated in standard operating procedures and protocols or are stipulated on a case by case basis depending on the nature of a specific issue. Results of the reviews will be documented in the SMA's Final Report.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	***Responsible Party*** *(check each that applies)*	***Frequency of data aggregation and analysis:*** *(check each that applies)*
	X *State Medicaid Agency*	✗ *Weekly*
	X *Operating Agency*	✗ *Monthly*
	✗ *Sub-State Entity*	✗ *Quarterly*
	✗ *Other: Specify:*	*X Annually*
		✗ *Continuously and Ongoing*
		✗ *Other: Specify:*

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c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

✦	**Yes** *(complete remainder of item)*
X	**No**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

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Appendix C-4: Additional Limits on Amount of Waiver Services

Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services *(check each that applies).*

✦	**Not applicable – The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.**
X	**Applicable – The State imposes additional limits on the amount of waiver services.**

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; and, (f) how participants are notified of the amount of the limit.

×	**Limit(s) on Set(s) of Services**. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver. *Furnish the information specified above.*
X	**Prospective Individual Budget Amount**. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant. *Furnish the information specified above.*
	Utilizing the score derived from the Personal Assistance Critical Needs Assessment and the needs identified in the InterRAI MINIMUM DATA SET - HOME CARE (MDS-HC), the administrative case manager estimates the participant's prospective budget amount. These assessments function as a benchmark during the annual person centered planning process. The participant's needs, amount, frequency and duration of available services are discussed with the participant. An individualized waiver services budget is agreed upon. The participant decides how the funds should be allocated among the waiver services. DSPD provides a central location for all administrative case managers in this waiver. The administrative case managers receive uniform training and engage in a cross review process, assuring the budget process is applied consistently to all waiver participants across the state. The waiver participant may contact the administrative case manager at any time to request a change in services or to request additional funding if the participant believes their budget is insufficient to meet health and safety requirements. The administrative case manager will review the request with the participant and may conduct a new MDS-HC if the request is due to a significant change in the participant's health status. The administrative case manager will present the reviewed request to the PD Waiver program manager for approval. If additional funding is approved, the administrative case manager notifies the participant and changes are made to the participant's PCSP to reflect the increase in funding. If the request is denied, the participant receives a Notice of Agency Action and information relating to their hearing rights.

	The process employed for determining individual budgets is open to public inspection during the development of the state implementation plan. During this time, the draft waiver implementation plan is made available, at a minimum, to providers, participants, the Indian Health Advisory Board, the Medical Care Advisory Committee and the public at large. The public is afforded the opportunity to provide feedback.
×	**Budget Limits by Level of Support**. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services. *Furnish the information specified above*.
×	**Other Type of Limit.** The State employs another type of limit. *Describe the limit and furnish the information specified above.*

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Appendix C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

Refer to Attachment #2.

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Appendix D-1: Service Plan Development

State Participant-Centered Service Plan Title:	Person Centered Support Plan (PCSP)

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(check each that applies)*:

X	**Registered nurse, licensed to practice in the State**
×	**Licensed practical or vocational nurse, acting within the scope of practice under State law**
×	**Licensed physician (M.D. or D.O)**
×	**Case Manager** (qualifications specified in Appendix C-1/C-3)
×	**Case Manager** (qualifications not specified in Appendix C-1/C-3). *Specify qualifications*:
×	**Social Worker** *Specify qualifications:*
X	**Other** *Specify the individuals and their qualifications:*
	Waiver participant

b. Service Plan Development Safeguards.

Select one:

X	**Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
✦	**Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.** The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify*:

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

In accordance with CFR 441. 301 (c) (1), the waiver includes the following processes to support the participant as appropriate to direct and be actively engaged in service plan development: (1) Person-centered planning process. The administrative case manager is responsible to ensure

the individual leads the person centered planning process where possible. As a part of pre-planning administrative case manager works with the individual to determine the role they would like to have in their upcoming meeting, any accommodations or support they may need from a representative (not a legal guardian), or family to accomplish this task, as well as any preparatory work that may be required to help them be successful.

In addition to being led by the individual receiving services and supports, the person-centered planning process:

(i) The administrative case manager may refer the individual to visit with their local Independent Living Center (ILC). The ILC will assist the participant to learn about available community resources.

(ii) The administrative case manager will provide training to the participants to ensure they are prepared to recruit, supervise and direct their own personal assistance services to fulfill the individualized PCSP.

(iii) Includes people chosen by the individual. The administrative case manager utilizes the pre-planning process to ask the individual who they would like to attend their person-centered planning meeting.

(iv) Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions. In addition to accommodations, supports, and preparation provided by the administrative case manager to the individual to help them lead their person-centered planning process, accommodations are made to ensure the individual can make informed choices and decisions. For example, the individual can take their plan home to think about it if they wish, pictures or graphics can be used to represent information in the plan although a written plan is also required, the administrative case manager can assist the individual to understand the array of services and providers that are available to them, etc.

(v) Is timely and occurs at times and locations of convenience to the individual. As a part of the pre-planning process the administrative case manager works with the individual to determine times and locations that will work for them and their chosen team. It is recommended that the administrative case manager begin the pre-planning process several weeks prior to the end of the previous 12 month cycle to ensure all aspects of the process are completed timely and times and locations are convenient for the individual.

(vi) Reflects cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with CFR 435.905(b). Administrative case managers are responsible to ensure the meeting is conducted in plain language and in a manner accessible to the individual. The administrative case manager assists individuals who are limited English proficient to

utilize Medicaid contracted interpretive services at no cost to the individual including, oral interpretation and written translations. Access to and use of auxiliary aids and services is supported by the administrative case manager and/or team at no cost to the individual in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act. The administrative case manager informs individuals of the availability of the accessible information and language services described in this paragraph and how to access such information and services.

(vii) Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants. The administrative case manager must authorize services according to documented and assessed needs, and the individual's choice and preferences. If assessments and/or other documentation do not support needs described by some members of the team, or documentation is conflicting, a new assessment can be requested by a different administrative case manager. The administrative case manager must inform the individual they can request a fair hearing in the event services are reduced, terminated, or denied as a part of the planning process. The administrative case manager provides timely notice of hearing rights in writing to the individual. Additionally, individuals can contact constituent services at the SMA or the OA at any point there is conflict or they are in disagreement with the process.

(viii) Those who have an interest in being employed by an individual to offer HCBS services, must not provide case management or develop the person-centered service plan.

(ix) Offers informed choices to the individual regarding the services and supports they receive and from whom. Administrative case managers are responsible to support individuals to make informed choices and decisions.

(x) Includes a method for the individual to request updates to the plan as needed. The administrative case manager informs the individual they may be contacted at any time to update the plan as needed.

(xi) The administrative case manager records the alternative home and community-based settings that were considered by the individual on the person-centered service plan.

d. Service Plan Development Process In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of

responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The PD Waiver administrative case manager, as part of the PCSP team, works in concert with the entire PCSP team to develop the PCSP. The PCSP team meets together at scheduled times and locations convenient to both the waiver participant and other individuals whom the participant has invited to participate. The administrative case manager is responsible to work with the individual and their authorized representative (if applicable) to negotiate a time and location which meets the preferences and schedules of those who will be participating in the planning meeting. As part of the process to develop the PCSP, the PCSP team identifies the waiver participant's strengths, goals, preferences, needs, capacities and desired outcomes. The PCSP is developed and implemented in a manner that supports the waiver participant and recognizes him/her as central to the process. The administrative case manager also works with the PCSP team to enable and assist the participant to identify and access a unique mix of services to meet the participant's assessed needs.

The PCSP is reviewed as frequently as necessary, with a formal review occurring at a minimum of annually (no later than by the end of the calendar month of the review, one year later). Annual individual budgets are developed with sufficient funds allocated to cover the array of services indicated in the PCSP. The PCSP and the budget are reviewed by the PCSP team and must be agreed upon by the participant and the administrative case manager. The PCSP and the budget are changed during the course of the year, as needed, to address participants' changing needs.

The primary assessment tool utilized to support service plan development is the MINIMUM DATA SET - HOME CARE (MDS-HC). Other assessments include: review of the previous year's assessment, the Person-Centered Profile, and educational, psychological, psychiatric, medical and other therapy evaluations as needed.

a) Who develops the plan, who participates in the process, and the timing of the plan;
The administrative case manager has ultimate responsibility to develop the PCSP; however, it is the entire PCSP team's responsibility to participate and develop the PCSP. The PCSP is reviewed and updated at least once a year with changes made throughout the year as needed based on the participant's needs. Anytime during the plan year the administrative case manager can choose to complete a whole new plan or make modifications (addendums) to the existing plan. The waiver participant or their representative may also request updates or changes to the existing plan outside of annual, formal reviews of the PCSP. Such requests would be addressed directly with the participant's administrative case manager. Once approved, service authorizations are provided to each of the selected agencies with the amount, frequency, duration, type and scope of the services they have been requested to provide. The administrative case manager works with the individual and the selected provided to determine service schedules (should the individual require assistance).

A final copy of the PCSP is constructed and signed by the participant and is retained by the OA.

(b) The types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences, strengths, capacities,

desired outcomes, risk factors, goals, and health status:
The PD Waiver utilizes a comprehensive approach to PCSP development. Important assessments include the Person Centered Profile, medical assessment, the MDS-HC and other therapy evaluations as needed and the review of the past year.

(c) How the participant is informed of the services that are available under the waiver:
Prior to the initial planning meeting with the PCSP team, the participant is given a list of all the services provided on the PD waiver including the definition of each service. In addition, the list of PD services is found on the DSPD website.

(d) How the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences:
The PCSP development process is based upon the participant's identified and expressed needs and strengths, as well as requirements for safe support in a community setting. The PCSP is created with the information gathered during the comprehensive assessment process using the MDS-HC to identify health care needs and based upon the contribution of the participant regarding their individual choices. The administrative case manager assists the participant to find out more information about individual providers. The waiver and non-waiver services are discussed with the PCSP team and based upon the participant's preferences; the frequency, duration and choice of provider are identified and included in the PCSP.

(e) How waiver and other services are coordinated:
The PCSP lists all the person's supports and services including: Formal/Written Support Strategies, Medicaid State Plan Services, Natural Supports, Specific Medical, Skill Training, Opportunities, Relationship development, etc.

The coordination of the PD Waiver and other services is a constant activity for the participant in services and the administrative case manager. Through quarterly face to face visits and monthly contacts with the participant, the administrative case manager is able to determine which services are being used successfully, what new services may be needed, if services are being duplicated and what services may need to be reviewed for effectiveness. The administrative case manager will document their activities in the Utah Systems for Tracking Eligibility, Planning and Services (USTEPS) log system.

(f) How the plan development process provides for the assignment of responsibilities to implement and monitor the plan.
The PCSP contains information about specific PD Waiver services, including details on amount, duration, and frequency. It also identifies supports and services, who is providing the support, date the support will begin and end and details including provider requirements, such as, objectives, methods, procedures, data reporting, etc. The PCSP also includes information related to communication and coordination of services or supports with others. The payment source is also identified. For supports funded by the PD Waiver, the name of the contracted provider, the service code and the requirement for support strategies are documented. The administrative case manager is responsible to monitor service provision on at least a monthly basis. This may involve direct contact with the participant, working with a servicing provider to determine progress/outcomes on assessed goals and is also responsible for reviewing provider requests for reimbursement.

(g) How and when the plan is updated, including when the participant's needs change:

The PCSP is reviewed and revised as frequently as necessary to address the participant's changing needs. A formal review occurs at least annually and is completed during the calendar month in which it is due.

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The administrative case manager, during the comprehensive needs assessment process and PCSP development process will identify: Risks posed by the participant's physical and environmental conditions and choice of services and supports to best meet the participant's needs. In completing the risk analysis, specific emphasis will be placed on identifying risks that would result in a high likelihood of harm, death or institutionalization if an interruption in the delivery of services and supports to the waiver participant occurred.

The risk analysis will be reviewed with the waiver enrollee and others of the participant's choosing. The PCSP will describe services and supports to be rendered to mitigate risks and will identify back-up plans for the provision of essential services. Back-up plans for individuals will identify natural supports or potentially other employees hired by the waiver participant who may be able to respond should a scheduled Personal Attendant not be available.

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

During the preparation of the written PCSP, the participant will be informed in writing by the administrative case manager of waiver service options available to address the identified needs and expectations of the participant. Provider options are made available for each selected waiver service.

The participant will be given a choice of all waiver services and waiver service providers. The participant selects the service(s) and provider(s) of their choice(s) and it is listed in their PCSP.

The process for assisting individuals to obtain information about and select from qualified providers reflects cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with CFR 435.905(b). Administrative case managers are responsible to ensure information is presented in plain language and in a manner accessible to the individual. The administrative case manager assists individuals who are limited English proficient to utilize Medicaid or OA contracted interpretive services at no cost to the individual including, oral interpretation and written translations. Access to and use of auxiliary aids and services is supported by the administrative case manager and/or team at no cost to the individual in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act. The administrative case manager informs individuals of the availability of the accessible information and language services described in this paragraph and how to access such information and services.

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The SMA retains final authority for oversight and approval of the person centered planning process. The oversight function involves reviews, occurring at a minimum of every two years, of a representative sample of waiver enrollees' PCSPs that are sufficient to provide a confidence level equal to 95% and a confidence interval equal to five. A response distribution equal to 50% will be used to gather base line data for the first waiver year. Base line data will be collected over a two year period with 50% of the total sample size collected each year. The response distribution used for further reviews will reflect the findings gathered during the base line review.

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

✦	**Every three months or more frequently when necessary**
✦	**Every six months or more frequently when necessary**
X	**Every twelve months or more frequently when necessary**
✦	**Other schedule** *Specify the other schedule*:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies)*:

×	**Medicaid agency**
X	**Operating agency**
×	**Case manager**
×	**Other** S*pecify:*

Appendix D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

This waiver maintains a person centered focus. As such, the participant has a responsibility to identify areas of concern and report problems to their administrative case manager. In return, the administrative case manager is expected to provide a prompt response to all waiver participant inquiries as well as any reported concerns.

The entire PCSP team will also work with the participant to identify goals. However, administrative case managers specifically have the ultimate responsibility to employ a person centered approach during the goal identification process and will utilize that same approach to develop and complete the PCSP prior to implementation.

The administrative case manager monitors the implementation of the PCSP as follows:

1.At a minimum, the administrative case manager and participant shall have a face-to-face visit on a quarterly basis (while quarterly face to face visits is the standard, the administrative case manager has the discretion to conduct face to face visits with the client more frequently than quarterly) One of the quarterly face to face visits will include the administration of the annual assessment of the MDS-HC for annual eligibility determination and person centered planning with the PCSP team.

2.Additional contacts will take place on at least a monthly basis to review progress including verification that: the waiver and state plan services the participant is receiving have been adequate in meeting their needs; whether the individual has had any health and welfare concerns such as the receipt of medical treatment or concerns defined in the State's critical incident protocol; and the effectiveness (or use of) backup plans that have been developed. The administrative case manager also reviews the billing statement from the Financial Management Service (FMS) provider and the monthly budget sheet provided by DSPD’s financial analyst. If these documents reveal over/under utilization, the administrative case manager contacts the participant to discuss the reasons why and then revises the budget if necessary.

The administrative case manager and officials of the Operating Agency and the SMA are afforded access to the participants that they serve at all times, with or without prior notice.If any members of the PCSP team believe that the PCSP is not being implemented as outlined, including the participant, they should immediately contact the administrative case manager to resolve the issue by following the informal and, if necessary, the formal resolution process as identified in Appendix F.

During the PCSP planning meeting, and at the waiver participant's request, information on all waiver services and available providers will be furnished.

Monitoring of PCSPs is conducted at least every two years by DHS/DSPD and at least every five years by the SMA. The sample size for each review will be sufficient to provide a confidence level equal to 95% and a confidence interval equal to five. Records are reviewed for documentation that demonstrates participants have been made aware of all services available on the PDW and have been offered choice among available providers. Records are also reviewed for compliance with health and welfare standards. This includes the documentation that

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prevention strategies are developed and implemented (when applicable) when abuse, neglect or exploitation is identified, verification (during face to face visits) that the safeguards and interventions are in place, notification of incidents to administrative case managers has occurred, documentation that administrative case managers have supported participants to explore what assistance may be available to assist with taking medications when needed, and verification that back up plans are effective. Records are also reviewed to determine that the PCSP addresses all of the participant's assessed needs, including health needs, safety risks and personal goals either by the provision of waiver services or other funding sources (State Plan services, generic services and natural supports). Significant findings from these reviews will be addressed with DHS/DSPD. A plan of correction with specific time frames for completion will be required. The SMA will conduct follow-up reviews as necessary to ensure the plan of correction is implemented and sustained.

Multiple monitoring methods are utilized to assess the effectiveness of back-up plans. The administrative case manager is required to have monthly contact with the individual to assure participant health and welfare. If a situation occurred where the individual needed to implement their back-up plan, the administrative case manager discusses with the individual whether or not the plan was effective and makes any necessary changes.

Additionally, the administrative case manager must take action on critical incident reports made for the individuals on their caseload. If an incident occurs which indicates a back-up plan needs to be changed, the administrative case manager must work with the individual to make these changes in order to prevent future problems from occurring. State staff review level one critical incidents and ensure back-up plans are updated as appropriate as a part of the investigation process. The State analyzes data for critical incidents to determine if administrative case manager follow-up occurred where necessary, and of those incidents requiring follow-up, whether recommended actions to protect individuals' health and welfare were implemented

Finally, the Quality Management Team with the Office of Quality and Design reviews individual back-up plans as a part of their consumer file audits. When problems are identified during monitoring, a corrective action plan is required. The SMA receives a detailed list of findings following the completion of annual compliance reviews. Ad hoc reviews can be completed and additional data provided as determined necessary by the OA or SMA.

The Choice of Services form, which includes information on freedom of choice of provider, is required annually as a part of the person-centered planning process for all individuals on the waiver. OQD reviews a statistically significant sample of these forms each year as a part of routine performance measure reviews to ensure the person has been informed of this choice, as evidenced by their signature. Health and safety issues must be addressed in an identified section within the person-centered plan as designed by the USTEPS system. Additionally, all goal and non-goal supports must be included in the person-centered plan, whether they are funded by the waiver or not. Annual consumer file reviews evaluate the number and percentage of PCSPs that address all participants' assessed needs including health needs, safety risks and personal goals either by the provision of waiver services or other funding sources including State Plan, generic and natural supports. The administrative case manager is responsible to monitor implementation of the person-centered service plan on at least a monthly basis for all waiver and non-waiver services, including health services. This may involve direct contact with the participant, working with the servicing provider to determine progress/outcomes on assessed goals, conducting a health status screening, and/or supporting a person to access needed community resources or entitlements. Annual consumer file reviews evaluate the number and percentage of administrative case manager monthly summary reports indicating that services are being

delivered in accordance with the PCSP.

b. Monitoring Safeguards. *Select one:*

X	**Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
✦	**Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.** The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify*:

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Service Plan Assurance**

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure: #2	*Number and percentage of participants for whom there is sufficient documentation to ascertain whether participants have made progress on goals identified on the PCSP. Numerator = number of PCSPs reviewed*

	that identify participant goals and for which there is sufficient documentation demonstrating progression of participants on those identified goals; Denominator = total number of PCSPs reviewed.		
Data Source ● *USTEPS* ● *PCSP*	*Responsible Party for data collection/generation (check each that applies)*	*Frequency of data collection/generation: (check each that applies)*	*Sampling Approach (check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	X Operating Agency	☐ *Monthly*	*X Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	*X Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error*
	☐ *Other: Specify:*	*X Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
Data Aggregation and Analysis	*Responsible Party for data aggregation and analysis (check each that applies*	*Frequency of data aggregation and analysis: (check each that applies*	
	☐ *State Medicaid Agency*	☐ *Weekly*	
	X Operating Agency	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	*X Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify: Every two years*	

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***Performance Measure:* #1**	**Number and percentage of PCSPs that address all participants' assessed needs including health needs, safety risks and personal goals either by the provision of waiver services or other funding sources including State Plan, generic and natural supports.** The numerator is the number of PCSPs in compliance; the denominator is the total number of PCSPs reviewed.		
Data Source ● **Risk Assessment** ● **PCSP** ● **USTEPS**	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	✗ *State Medicaid Agency*	✗ *Weekly*	✗ *100% Review*
	X *Operating Agency*	✗ *Monthly*	**X** *Less than 100% Review*
	✗ *Sub-State Entity*	✗ *Quarterly*	**X** *Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error*
	✗ *Other: Specify:*	*X Annually*	
		✗ *Continuously and Ongoing*	✗ *Stratified: Describe Groups*
		X *Other: Specify: Every two years*	
			✗ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	✗ *State Medicaid Agency*	✗ *Weekly*	
	X *Operating Agency*	✗ *Monthly*	
	✗ *Sub-State Entity*	✗ *Quarterly*	
	✗ *Other: Specify:*	✗ *Annually*	
		✗ *Continuously and Ongoing*	
		✗ *Other: Specify:*	

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Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.

ii. Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure: #2	*Number and percentage of PCSPs which are updated/revised when warranted by changes in the participant's needs. The numerator is the number of PCSPs which were updated/revised; the denominator is the total number of PCSPs which required updates/revision due to a change in need.*		
Data Source ● *USTEPS* ● *PCSP*	*Responsible Party for data collection/generation (check each that applies)*	*Frequency of data collection/generation: (check each that applies)*	*Sampling Approach (check each that applies)*
	☐ State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error*
	☐ Other: Specify:	*X Annually*	
		☐ Continuously and Ongoing	*☐ Stratified: Describe Groups*
		☐ Other: Specify:	

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			☐ *Other: Describe*
Data Aggregation and Analysis	*Responsible Party for data aggregation and analysis (check each that applies*	*Frequency of data aggregation and analysis: (check each that applies*	
	☐ *State Medicaid Agency*	☐ *Weekly*	
	X Operating Agency	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	*X Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

***Performance Measure:* #1**	**Number and percentage of PCSPs reviewed and updated annually, completed during the calendar month in which it is due.** The numerator is the number of reviewed PCSPs for which a review shows it was updated annually, completed during the calendar month in which it is due; the denominator is the total number of PCSPs reviewed.		
Data Source ● **USTEPS** ● **PCSP**	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	✗ *State Medicaid Agency*	✗ *Weekly*	✗ *100% Review*
	X *Operating Agency*	✗ *Monthly*	**X** *Less than 100% Review*
	✗ *Sub-State Entity*	✗ *Quarterly*	**X** *Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error*
	✗ *Other: Specify:*	*X Annually*	
		✗ *Continuously and Ongoing*	✗ *Stratified: Describe Groups*
		✗ *Other: Specify:*	

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			✗ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	✗ *State Medicaid Agency*	✗ *Weekly*	
	X *Operating Agency*	✗ *Monthly*	
	✗ *Sub-State Entity*	✗ *Quarterly*	
	✗ *Other: Specify:*	*X Annually*	
		✗ *Continuously and Ongoing*	
		✗ *Other: Specify: Every two years*	

iii. Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

***Performance Measure:* #1**	**Number and percentage of PCSPs identifying the type, scope, amount, frequency and duration for each service authorized.** The numerator is the total number of PCSPs in the review which clearly identify the amount, frequency and duration for each waiver service authorized; the denominator is the total number of PCSPs reviewed.		
Data Source ● **PCSP**	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	✗ *State Medicaid Agency*	✗ *Weekly*	✗ *100% Review*
	X *Operating Agency*	✗ *Monthly*	**X** *Less than 100% Review*
	✗ *Sub-State Entity*	✗ *Quarterly*	**X** *Representative Sample; Confidence Interval = 95%*

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			Confidence Level, 5% Margin of Error
	✗ *Other: Specify:*	*X Annually*	
		✗ *Continuously and Ongoing*	✗ *Stratified: Describe Groups*
		✗ *Other: Specify:*	
			✗ *Other: Describe*

Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	✗ *State Medicaid Agency*	✗ *Weekly*	
	X *Operating Agency*	✗ *Monthly*	
	✗ *Sub-State Entity*	✗ *Quarterly*	
	✗ *Other: Specify:*	*X Annually*	
		✗ *Continuously and Ongoing*	
		✗ *Other: Specify:*	

***Performance Measure:* #2**	*The number and percentage of participants whose record contains documentation they were contacted by their case managers monthly, either by phone or in person, to monitor the delivery and quality of services provided. (N = # of cases where evidence of monthly contact occurred; D = total # of cases reviewed)*		
Data Source ● **USTEPS**	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	✗ *State Medicaid Agency*	✗ *Weekly*	✗ *100% Review*
	X *Operating Agency*	✗ *Monthly*	**X** *Less than 100% Review*
	✗ *Sub-State Entity*	✗ *Quarterly*	**X** *Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error*
	✗ *Other: Specify:*	*X Annually*	
		✗ *Continuously and Ongoing*	✗ *Stratified: Describe Groups*
		✗ *Other: Specify:*	

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			✗ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	✗ *State Medicaid Agency*	✗ *Weekly*	
	X *Operating Agency*	✗ *Monthly*	
	✗ *Sub-State Entity*	✗ *Quarterly*	
	✗ *Other: Specify:*	*X Annually*	
		✗ *Continuously and Ongoing*	
		✗ *Other: Specify: Every two years*	

iv. Sub-assurance: Participants are afforded choice: between/among waiver services/providers.

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

***Performance Measure:* #1**	**Number and percentage of participants who are made aware of all services available on the PD Waiver.** The numerator is the total number of participants reviewed who were made aware of all services available on the PD Waiver; the denominator is the total number of participants reviewed.		
Data Source ● **USTEPS** ● **PCSP**	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	✗ *State Medicaid Agency*	✗ *Weekly*	✗ *100% Review*
	X *Operating Agency*	✗ *Monthly*	**X** *Less than 100% Review*
	✗ *Sub-State Entity*	✗ *Quarterly*	**X** *Representative Sample; Confidence*

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			Interval = 95% Confidence Level, 5% Margin of Error
	✗ *Other: Specify:*	*X Annually*	
		✗ *Continuously and Ongoing*	✗ *Stratified: Describe Groups*
		✗ *Other: Specify:*	
			✗ *Other: Describe*

Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	✗ *State Medicaid Agency*	✗ *Weekly*	
	X *Operating Agency*	✗ *Monthly*	
	✗ *Sub-State Entity*	✗ *Quarterly*	
	✗ *Other: Specify:*	*X Annually*	
		✗ *Continuously and Ongoing*	
		✗ *Other: Specify:*	

***Performance Measure:* #2**	**Number and percentage of participants who are offered choice among providers when more than one is available.** The numerator is the total number of participants reviewed who are offered choice among providers when more than one is available; the denominator is the total number of participants reviewed.		
Data Source ● **USTEPS** ● **PCSP**	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	✗ *State Medicaid Agency*	✗ *Weekly*	✗ *100% Review*
	X *Operating Agency*	✗ *Monthly*	***X*** *Less than 100% Review*
	✗ *Sub-State Entity*	✗ *Quarterly*	***X*** *Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error*
	✗ *Other: Specify:*	*X Annually*	

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Effective Date	

		✗ *Continuously and Ongoing*		✗ *Stratified: Describe Groups*
		✗ *Other: Specify:*		
				✗ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*		
	✗ *State Medicaid Agency*	✗ *Weekly*		
	X *Operating Agency*	✗ *Monthly*		
	✗ *Sub-State Entity*	✗ *Quarterly*		
	✗ *Other: Specify:*	*X Annually*		
		✗ *Continuously and Ongoing*		
		✗ *Other: Specify:*		

v. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

The PCSP team works together to develop the PCSP and must include, at a minimum, the participant and/or the participant's representative and administrative case manager. All other individuals participating in the PCSP planning process attend at the invitation of the participant. The PCSP team must address health needs, safety risks and personal goals. Documentation in the participant's record will contain adequate information to ascertain the progress that a participant has made on goals identified in the PCSP. Once an individual is enrolled in the waiver they are to receive the amount of covered services necessary to meet their health and safety needs and to prevent unnecessary institutionalization. If there have been significant changes, the assessment is updated. All services are identified on the PCSP regardless of funding source. Participants are offered choice of either nursing facility care or PD Waiver services and choice is documented on the PCSP. Participants are made aware of all services available on the PD Waiver and are offered choice among providers whenever choice exists.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem*

correction. In addition, provide information on the methods used by the State to document these items.

Individual issues identified by DSPD and the SMA that affect the health and welfare of individual participants are addressed immediately. Issues that are less immediate are corrected within designated time frames and are documented through the SMA Final Report. When the SMA determines that an issue is resolved, notification is provided and documentation is maintained by the SMA.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	***Responsible Party*** *(check each that applies)*	***Frequency of data aggregation and analysis:*** *(check each that applies)*
	X *State Medicaid Agency*	✗ *Weekly*
	X *Operating Agency*	✗ *Monthly*
	✗ *Sub-State Entity*	✗ *Quarterly*
	✗ *Other: Specify:*	✗ *Annually*
		✗ *Continuously and Ongoing*
		X Other: Specify: Every two years

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

✦	**Yes** *(complete remainder of item)*
X	**No**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request):*

X	**Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
✦	**No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

✦	**Yes. The State requests that this waiver be considered for Independence Plus designation.**
X	**No. Independence Plus designation is not requested.**

Appendix E-1: Overview

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Self-Administered Services (SAS) means service delivery that is provided through a non-agency based provider. Under this method, waiver participants are required to employ individual employees in order to receive personal assistance waiver services. The waiver participant is then responsible to perform the functions of hiring and supervising their employee, assuring that employee qualifications are met, scheduling the employee's time, assuring accuracy of the time sheets, etc.

The SAS method necessitates the use of Financial Management Services (FMS), commonly known as a "Fiscal Agent", to assist with managing employer-related financial responsibilities associated with SAS. These employer-related financial responsibilities include federal, state, and local tax withholding/payments, fiscal accounting, expenditure reports, Medicaid claims processing and reimbursement distribution. Administrative case managers are responsible to assist participants to successfully direct their personal attendance services.

The participant has budget authority as it pertains to their personal assistance staff. The participant decides how many employees they can afford to hire within the overall budgeted amount, the wages to be paid and the amount of hours worked. They are responsible to review all employee timesheets for accuracy and submit them to the FMS agent for payment. The FMS agent sends the employer information after each pay period detailing what was paid and the amount remaining in their budget.

Waiver participants and/or their representatives hire employees in accordance with Federal Internal

Revenue Service ("IRS") and Federal and State Department of Labor ("DOL") rules and regulations (IRS Revenue Ruling 87-41; IRS Publication 15-A: Employer's Supplemental Tax Guide; Federal DOL Publication WH 1409, Title 29 CFR Part 552, Subpart A, Section 3: Application of the Fair Labor Standards Act to Domestic Service; and States= ABC Test).

For persons utilizing the Self-Directed Services method, Financial Management Services are offered in support of the self-directed option. Financial Management Services, (commonly known as a "Fiscal Agent") facilitate the employment of individuals by the waiver participant or designated representative including:
(a) provider qualification verification,
(b) employer-related activities including federal, state, and local tax withholding/payments, fiscal accounting and expenditure reports, and
(c) Medicaid claims processing and reimbursement distribution.

The participant receiving waiver services remains the employer of record, retaining control over the hiring, training, management, and supervision of employees who provide direct care services. Once a person's needs have been assessed, the Person Centered Support Plan and budget have been developed and the participant chooses to participate in Self-Directed Services, the participant will be provided with a listing of the available Financial Management Services providers from which to choose. The participant will be referred to the Financial Management Services provider once a selection is made. A copy of the participant's support plan/approved budget worksheet will be given to the chosen provider of Financial Management Services. The worksheet will indicate the person's total number of authorized funds. Allocated funds are only disbursed to pay for actual services rendered. All payments are made through Financial Management Services providers under contract with the Division of Services for People with Disabilities. Payments are not issued to the waiver participant, but to and in the name of the employee hired by the person. The person will be authorized for a rate to cover the costs of the employee wages and benefits reimbursement. The administrative case manager monitors payments, reviews actual expenditure in comparison with the individual support plan and budget, contacts the waiver participant or their representative if any concerns arise, and assists in resolution of billing problems.

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one:*

✦	**Participant – Employer Authority**. As specified in ***Appendix E-2, Item a,*** the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
✦	**Participant – Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
X	**Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

X	**Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
○	**Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
○	**The participant direction opportunities are available to persons in the following other living arrangements** *Specify* these living arrangements:

d. Election of Participant Direction. Election of participant direction is subject to the following policy (s*elect one):*

X	**Waiver is designed to support only individuals who want to direct their services.**
✦	**The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
✦	**The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.** *Specify the criteria*

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

During the eligibility and enrollment process the administrative case manager provides the participant with an individualized orientation to waiver home and community based services, which involves providing written materials as well as describing services available under the self-directed model. The orientation typically occurs at the initial visit when the individual is transitioning into services, after needs have been assessed but prior to developing the support plan and approving the individual's budget. At that time it is further explained that by using the self-directed model, it is required that the participant use a qualified Financial Management Service Agency to assist them with payroll functions. The responsibilities and potential liabilities of becoming an employer are also discussed using the Self-Administered Support book as a guide. Administrative case managers are trained on all information within the book which includes an introduction to SAS services, definitions, service descriptions, the SAS agreement, roles and responsibilities, background screenings, incident reporting, time sheets, rate information, compliance reviews, record keeping, and other resources. The SAS booklet is available on the DSPD website in both English and Spanish.

Individuals transitioning onto the waiver have sufficient time to weigh the pros and cons, gather more information, and ask questions before utilizing participant direction as they are given the information early in the process. While the State aims to transition individuals into services in a

timely manner, administrative case managers provide individuals with the information and time they need to make an informed choice regarding participant direction.

The process for providing information about participant direction opportunities reflects cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with CFR 435.905(b). Administrative case managers are responsible to ensure information is presented in plain language and in a manner accessible to the individual. The administrative case manager assists individuals who are limited English proficient to utilize Medicaid or OA contracted interpretive services at no cost to the individual including, oral interpretation and written translations. Access to and use of auxiliary aids and services is supported by the administrative case manager and/or team at no cost to the individual in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act. The administrative case manager informs individuals of the availability of the accessible information and language services described in this paragraph and how to access such information and services.

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative *(select one)*:

X	**The State does not provide for the direction of waiver services by a representative.**	
✦	**The State provides for the direction of waiver services by representatives.** Specify the representatives who may direct waiver services: *(check each that applies)*:	
	○	**Waiver services may be directed by a legal representative of the participant.**
	○	**Waiver services may be directed by a non-legal representative freely chosen by an adult participant.** Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3. *(Check the opportunity or opportunities available for each service)*:

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Personal Attendant Services	X	X
	○	○
	○	○
	○	○
	○	○
	○	○

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

X	**Yes**. **Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

	Specify whether governmental and/or private entities furnish these services. *Check each that applies:*
	○ **Governmental entities**
	X **Private entities**
✦	**No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. S*elect one*:

X	FMS are covered as the waiver service specified in Appendix C-1/C-3 **The waiver service entitled:**	Financial Management Services
✦	**FMS are provided as an administrative activity.** ***Provide the following information***	
i.	**Types of Entities**: Specify the types of entities that furnish FMS and the method of procuring these services:	
	The State uses private vendors to furnish FMS. Any qualified, willing provider may enroll to offer this service. The procurement method is the same as with all other services.	
ii.	**Payment for FMS**. Specify how FMS entities are compensated for the administrative activities that they perform:	
	Not applicable. FMS is not an administrative function.	
iii.	**Scope of FMS**. Specify the scope of the supports that FMS entities provide *(check each that applies):*	
	Supports furnished when the participant is the employer of direct support workers:	
	X **Assists participant in verifying support worker citizenship status**	
	X **Collects and processes timesheets of support workers**	
	X **Processes payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**	
	X **Other** *Specify:*	
	Financial Management Services (FMS) will assist individuals in the following activities: 1. Verify that the employee completed the following forms: a. Form I-9, including supporting documentation (i.e. copies of driver's license, social security card, passport). If fines are levied against the person for failure to report INS information, the Fiscal Agent shall be responsible for all such fines. b. Form W-4	

2. Obtain a completed and signed Form 2678, Employer Appointment of Agent, from each person receiving services from the Financial Management Services provider, in accordance with IRS Revenue Procedure 70-6, 1970-1 C.B. 420.

3. Provide persons with a packet of all required forms when using an FMS provider, including all tax forms (IRS Forms I-9, W-4 and 2678), payroll schedule, FMS provider's contact information and training material for the web-based timesheet.

4. Process and pay Utah Department of Human Services/DSPD approved employee timesheets, including generating and issuing paychecks to employees hired by the participant.

5. Assume all fiscal responsibilities for withholding and depositing FICA and SUTA/FUTA payments on behalf of the person. Any federal and/or State penalties assessed for failure to withhold the correct amount and/or timely filing and depositing will be paid by the FMS provider.

6. Maintain a customer service system for persons and employees who may have billing questions or require assistance in using the web-based timesheet. The FMS provider will maintain an 800-number for calls received outside the immediate office area. Messages must be returned within 24 hours Monday thru Friday. Messages left between noon on Friday and Sunday evening shall be returned the following Monday.

a. Must have capabilities in providing assistance in English and Spanish. Fiscal Agent must also communicate through TTY, as needed, for persons with a variety of disabilities.

7. File consolidated payroll reports for multiple employers. The FMS provider must obtain federal designation as an FMS provider under Internal Revenue Services' (IRS) Rule in 26 CFR § 31.3504 (Acts to be Performed by Agents). An FMS provider must make an election with the appropriate IRS Service Center via Form 2678 (Employer Appointment of Agent). The FMS provider must carefully consider if they want to avail the Employers of the various tax relief provisions related to domestics and family employers. The FMS provider may forego such benefits to maintain standardization. Treatment on a case-by-case basis is tedious, and would require retroactive applications and amended employment returns. The FMS provider will, if required, comply with IRS Regulations in 26 CFR §§ 31.3306(a)(3)(c)(2), 31.3506, 31.3306(c)(5)-1 and 31.3506 (all parts), together with IRS Publication 926, Household Employer's Tax Guide. In order to be fully operational, the Form 2678 election should be postured to fall under two vintages yet fully relevant IRS Revenue Procedures: IRS Revenue Procedure 70-6, 1970-1 C.B. 420 allows the FMS provider to file one employment tax return, regardless of the number of employers they are acting for, provided the FMS provider has a properly executed Form 2678 from each Employer; and IRS Revenue Procedure 80-4, 1980-1 C.B. 581 amplifies IRS Revenue Procedure 70-6, 1970-1 C.B. 420, and does away with the multiple Form 2678 requirements, by imposing more stringent record keeping requirements on the FMS provider.

8. Obtain IRS approval for Agent status. The FMS provider shall consolidate the

		federal filing requirements, obtain approval for Utah State Tax Commission consolidated filings, and obtain approval for consolidated filing for unemployment insurance through the Department of Workforce Services. For those Employers retaining domestic help less than 40 hours per week, Workers Compensation coverage is optional. If the 40-hour threshold is achieved or exceeded, the Worker's Compensation Act requires coverage. Statutory requirements and the nature of insurance entail policies on an individual basis. Consolidated filings of Workers Compensation are not an option. 9. The FMS provider cannot provide waiver recipients with community-based services in addition to FMS.
	Supports furnished when the participant exercises budget authority:	
	○	**Maintains a separate account for each participant's participant-directed budget**
	○	**Tracks and reports participant funds, disbursements and the balance—of participant funds**
	○	**Processes and pays invoices for goods and services approved in the service plan**
	○	**Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
	○	**Other services and supports** *Specify*:
	Additional functions/activities:	
	X	**Executes and holds Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
	X	**Receives and disburses funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
	X	**Provides other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
	○	**Other** *Specify:*
iv.	**Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.	
	Service providers, administrative case managers and others, who assist in the development and delivery of supports for people served through DSPD, will be expected to maintain established standards of quality. The SMA and DSPD will assure that high standards are maintained by way of a comprehensive system of quality assurance including: (a) formal surveys of providers for measurement of individual and organizational outcomes, (b) contract compliance reviews, (c) regular observation and evaluation by administrative case managers, (d) provider quality assurance systems, (e) participant/family satisfaction measures, (f) performance	

	contracts with and reviews of State agency staff, (g) audits completed by entities external to the agency and (h) other oversight activities as appropriate. DSPD improved the accountability of SAS service delivery through standardized mandatory training and manuals for SAS families and administrative case managers and a formal documentation monitoring tool used by administrative case managers to audit SAS employers.

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

○	**Case Management Activity**. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. *Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:*
X	**Waiver Service Coverage**. Information and assistance in support of participant direction are provided through the waiver service coverage (s) specified in Appendix C-1/C-3 (check each that applies):

	Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
	Financial Management Services	X

X	**Administrative Activity**. Information and assistance in support of participant direction are furnished as an administrative activity. *Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and (e) the entity or entities responsible for assessing performance:*
	In order to provide information and assistance to participants about self-directing their services, the administrative case manager is responsible to provide the participant with a Self-Directed Services Support Book. The administrative case manager reviews the information in the Support Book with the participant and is available to answer any questions and provide assistance as needed. The administrative case manager is responsible to assess whether the information provided is sufficient to meet the needs of the participant. If the assessment of the situation shows that the participant requires additional training - such as hiring, scheduling, or training of employees, the administrative case manager will contact the Financial Management Services agency to provide more detailed training on how to self-direct services. The administrative case manager monitors payments, reviews actual expenditures in comparison with the PCSP and budget, contacts the waiver participant if any concerns arise, and assists in resolution of billing problems.

k. Independent Advocacy *(select one)*.

X	**No. Arrangements have not been made for independent advocacy.**
✦	**Yes**. Independent advocacy is available to participants who direct their services. *Describe the nature of this independent advocacy and how participants may access this*

	advocacy:

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

The PD Waiver supports only those individuals who are willing and capable to self-direct their own services. If a participant voluntarily chooses not to self-direct their services, the process of transitioning the person out of the PD Waiver will begin. During the transition period, coordination of necessary health and welfare supports is provided through the waiver until the person is enrolled in another program that will meet their needs.

The Division of Medicaid and Health Financing (DMHF), in partnership with DSPD, will compile information on voluntary disenrollments.

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

The PD Waiver supports only those individuals who are willing and capable of self-directing their own services. When participants struggle with self-administering their services, the administrative case manager will make several attempts to assist the participant in acquiring the skills necessary for self-administration. Only after a participant repeatedly demonstrates an incapacity for self-administration, or fraud/malfeasance are substantiated, would the process of transitioning the person out of the PD Waiver begin. During the transition period, coordination of necessary health and welfare supports is provided through the waiver until the person is enrolled in another program that will meet their needs.

Participants may appeal any involuntary termination under the procedures found in Appendix F.

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	**Budget Authority Only or Budget Authority in Combination with Employer Authority**
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		105

Year 2		105
Year 3		105
Year 4 (only appears if applicable based on Item 1-C**)**		105
Year 5 (only appears if applicable based on Item 1-C**)**		105

State:	
Effective Date	

Appendix E-2: Opportunities for Participant-Direction

a. Participant – Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both:*

○	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions. Specify the types of agencies (a.k.a., "agencies with choice") that serve as co-employers of participant-selected staff:
X	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

X	**Recruit staff**
X	**Refer staff to agency for hiring (co-employer)**
○	**Select staff from worker registry**
X	**Hire staff (common law employer)**
X	**Verify staff qualifications**
X	**Obtain criminal history and/or background investigation of staff** Specify how the costs of such investigations are compensated:
	DSPD is responsible to pay any fees associated with background investigations.
X	**Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
X	**Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
X	**Determine staff wages and benefits subject to applicable State limits**
X	**Schedule staff**
X	**Orient and instruct staff in duties**
X	**Supervise staff**

X	**Evaluate staff performance**
X	**Verify time worked by staff and approve time sheets**
X	**Discharge staff (common law employer)**
○	**Discharge staff from providing services (co-employer)**
○	**Other** Specify:

b. Participant – Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more***:**

○	**Reallocate funds among services included in the budget**
X	**Determine the amount paid for services within the State's established limits**
X	**Substitute service providers**
X	**Schedule the provision of services**
X	**Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
X	**Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
X	**Identify service providers and refer for provider enrollment**
○	**Authorize payment for waiver goods and services**
X	**Review and approve provider invoices for services rendered**
○	Other Specify:

ii. Participant-Directed Budget. Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Utilizing the score derived from the Personal Assistance Critical Needs Assessment and the assessment information from the MDS-HC, the administrative case manager estimates the participant's prospective budget amount. During the annual person centered planning process, the participant's needs and available services are discussed with the participant. An individualized waiver services budget is agreed upon. The participant, in collaboration with the administrative case manager, decides how the funds should be allocated among the waiver services to assure the health and safety of the participant.

The process employed for determining participant-directed budgets is open to public inspection during the development of the state implementation plan. At a minimum, the draft waiver implementation plan is made available to providers, participants, the Indian Health Advisory Board, the Medical Care Advisory Committee and the public at large. The public is afforded the opportunity to provide feedback.

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Once the draft plan is drawn up, the administrative case manager communicates the amount budgeted for each type of service included in the plan.

Each month the participant receives a report from the FMS Fiscal Agent that provides information on the budgeted amount utilized and the funds remaining. The participant can also contact the administrative case manager at any time to find out the current balance of the budget. The administrative case manager reviews what has been spent each month and monitors whether the plan needs any adjustments due to crisis, loss of caregiver or other deterioration in participant functioning.

If at any time the participant's service needs change or a health and safety issue arises, the participant is responsible to contact their administrative case manager with these changes. If the participant requests an increase in their services, they may petition in writing for additional funds. The administrative case manager will complete a new MDS-HC, Critical Needs Assessment and review the present PCSP. These documents are presented to the PD Waiver Program Manager for review.

If additional funding is approved, the administrative case manager notifies the participant, changes are made to the participant's PCSP and funding allocation plan. If the request is denied, the participant receives a Notice of Agency Action and information relating to their hearing rights.

iv. Participant Exercise of Budget Flexibility. *Select one:*

X	**Modifications to the participant directed budget must be preceded by a change in the service plan.**
✦	**The participant has the authority to modify the services included in the participant directed budget without prior approval.** Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Each month the administrative case manager reviews the billing statement from the Financial Management Services provider and a monthly budget sheet from DSPD's financial analyst. If these documents reveal over/under utilization, the administrative case manager contacts the participant to discuss the reasons why and will revise the budget if necessary.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

RIGHTS TO A FAIR HEARING DOCUMENTATION

A participant and the participant's legal representative will receive a written Notice of Agency Action, Form 522 and a Hearing Request Form 490S from a DSPD administrative program manager, if the participant is denied a choice of institutional or waiver program, found ineligible for the waiver program, or denied access to the provider of choice for a covered waiver service or experiences a denial, reduction, suspension, or termination in waiver services in accordance with R539-2-5. If the participant is enrolled in services, the State follows regulation in accordance with 42 CFR §431.230. In instances in which a participant is found to be ineligible for entrance to the waiver, they may request an administrative fair hearing from the Depart of Human Services, which is dispositive. Services are not afforded during this period of pendency.

The Notice of Agency Action delineates the participant's right to appeal the decision through an informal hearing process at the Department of Human Services or an administrative hearing process at the Department of Health, or both. The participant is encouraged to utilize an informal dispute resolution process to expedite equitable solutions.

Notices and the opportunity to request a fair hearing documentation are kept in the participant's case record/file and at the Operating Agency - State Office.

The process for assisting individuals to obtain information about a fair hearing reflects cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with CFR 435.905(b). Administrative case managers are responsible to ensure information is presented in plain language and in a manner accessible to the individual. The administrative case manager assists individuals who are limited English proficient to utilize Medicaid or OA contracted interpretive services at no cost to the individual including, oral interpretation and written translations. Access to and use of auxiliary aids and services is supported by the administrative case manager and/or team at no cost to the individual in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act. The administrative case manager informs individuals of the availability of the

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accessible information and language services described in this paragraph and how to access such information and services. Support coordinators are asked to assist individuals to request a fair hearing if an adverse decision has been made regarding waiver eligibility, amount, frequency, and duration of waiver services and/or choice of providers from which to receive waiver services.

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Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one*:

✦	**No. This Appendix does not apply**
X	**Yes. The State operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The Department of Human Services has an informal hearings process and DSPD has an informal dispute resolution process. The informal dispute resolution process is designed to respond to a participant's concerns without unnecessary formality. The dispute resolution process is not intended to limit a participant's access to formal hearing procedures; the participant may file a Request for Hearing any time in the first 30 days after receiving Notice of Agency Action. Examples of the types of disputes include but are not limited to: concerns with a provider of waiver services, concerns with the amount, frequency or duration of services being delivered, concerns with provider personnel, etc.

When DSPD receives a Hearing Request Form (490S), a two-step resolution process begins with:

1. The Division staff explain the regulations on which the action is based and attempt to resolve the disagreement; and then,
2. If a resolution is not reached, DSPD staff arrange a review meeting between the participant and the DSPD Director (Director) or the Director's designee.

Attempts to resolve disputes are completed as expeditiously as possible. No specific time frame has been set due to the fact that some issues may be resolved very rapidly while other, more complex issues may take a greater period of time to resolve. Expectations surrounding follow-up time frames are communicated to the individual with methods for direct contact provided in the event additional questions or concerns are found.

If the two-step resolution process is not able to resolve the problem, the participant may request an informal hearing with a hearing officer with the Department of Human Services Office of Administrative Hearings.

This informal hearing reviews the information DSPD used to make a decision or take an action as well as review information from the participant and/or their legal representative demonstrating why the decision or action is not correct.

DSPD Policy 1.11 Conflict Resolution requires the support coordinator to provide information to waiver participants on the conflict resolution process and on how to contact the Division. The Division reviews all complaints submitted either orally or written and any relevant information

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submitted with the complaint. The Division will take appropriate action to resolve the dispute and respond to all parties concerned. If the parties are unable to resolve the dispute either party may appeal to the Division Director or the Director's designee.

The Director or designee will meet with the parties and review any evidence presented. The Director or designee shall determine the best solution for the dispute. The Director or designee will prepare a concise written summary of the finding and decision and send it to the parties involved. Either party may request an independent review if they do not agree with the Director's decision. Based on interviews with the parties and a review of the evidence, the independent reviewer will prepare for the Division Director a written summary of the factual findings and recommendations. Based on the independent reviewers report the Division Director will determine the appropriate resolution for the dispute and shall implement any necessary corrective action.

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Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

✦	**No. This Appendix does not apply**
X	**Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

The Utah Department of Human Services, Division of Services for People with Disabilities, and the Utah Department of Health, Division of Medicaid and Health Financing, Bureau of Authorization and Community Based Services.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

PD Waiver participants may file a written or verbal complaint/grievance with the Utah Department of Human Services /Division of Services for People with Disabilities Constituent Services Representative (Representative). There is no limit to the amount of elapsed time that has occurred when a complaint may be filed. This Representative is specifically assigned to DSPD, although operates independent of them. When the Representative receives a complaint there is an investigation involving all pertinent parties. The Representative then works with the parties to come to a resolution.

Both the Department of Human Services and the Utah Department of Health have constituent services available. Participants may call and verbally register a complaint/grievance. The respective constituent services representative ensures the caller is referred to the appropriate party for problem resolution.

The types of complaints that can be addressed through the grievance/complaint system include but are not limited to: Complaints about a provider of waiver services, complaints about the way in which providers deliver services, complaints about individual personnel within a provider agency, etc.

The Quality Assurance Team within the Bureau of Authorization and Community Based Services investigates complaints/grievances that are reported to the SMA and pertain to the operation of the PD Waiver. The SMA makes all efforts to resolve the complaint/grievance to the satisfaction of all parties within two weeks of the submission of the complaint/grievance. Some complaints/grievances may require additional time to investigate and implement a resolution. Findings and resolutions of all complaints/grievances are documented by fiscal year

in the SMA complaint/grievance data base. Participants are informed that filing a complaint is not a prerequisite or a substitute for a hearing.

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Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program. *Select one*:

X	**Yes**. **The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
✦	**No**. **This Appendix does not apply** (*do not complete Items b through e).* *If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.*

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents, and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

State Medicaid Agency (DOH) Critical Event or Incident Reporting Requirements:

The SMA requires that DHS/DSPD report critical events/incidents within 24 hours of the event that occurs either to or by a participant. Reportable incidents or events include: unexpected or accidental deaths, suicide attempts, medication errors that lead to death or medical treatment, abuse or neglect that results in death, hospitalization or other medical treatment (inpatient or outpatient care), accidents that result in hospitalization, missing persons, human rights violations such as unauthorized use of restraints, criminal activities that are performed by or perpetrated on waiver participants (including sexual abuse), events that compromise the participant's working or living environment that put a participant(s) at risk, and events that are anticipated to receive media, legislative, or other public scrutiny. The SMA and OA determine who will be responsible for the oversight of the investigation based on the severity/type of incident.

Operating Agency (DSPD) Critical Event or Incident Reporting Requirements:
R539-5-6 requires the participant/ their representative or a provider agency to report to the case manager if at any time the participant's health and/or safety is jeopardized. Such instances may include, but are not limited to:
1. Actual or suspected incidents of abuse, neglect, exploitation or maltreatment per the DHS/DSPD Code of Conduct and Utah Code Annotated Sections 62-A-3-301 through 321 (mandatory reporting to Adult Protective Services)
2. Drug or alcohol misuse

3. Medication overdose or error requiring medical intervention
4. Missing person
5. Evidence of a seizure in person with no seizure diagnosis
6. Significant property destruction ($500.00 or more)
7. Physical injury requiring medical intervention
8. Law enforcement involvement
9. Emergency hospitalizations

The death of a waiver recipient is subject to a full review of the circumstances surrounding the death and includes a review of documentation by the DSPD Fatality review Coordinator for the most recent year of services. The DHS Fatality Review Committee meets at least quarterly and reports annually to DHS and SMA leadership.

Incidents that require reporting may be done verbally and must be made within 24 hours. Within 5 days the person reporting the incident completes and submits the DSPD Form 1-8 to the administrative case manager. If the person reporting is unable to complete the DSPD Form 1-8, accommodations are made and the administrative case manager completes Form 1-8.

The administrative case manager reviews the information, develops and implements a follow-up plan, as appropriate. The form and any follow-up conducted are filed in the individual's case record.

Incident reports are compiled, logged into the DSPD electronic database, analyzed and trends are identified. The information is utilized by the DSPD to identify potential areas for quality improvement. The DSPD generates a summary report of the incident reports annually and submits to the SMA.

The SMA reviews the report to assure systemic issues have been addressed. In the event the SMA determines that a system issue has not been adequately addressed DSPD will submit a plan of correction to the SMA. All plans of correction are subject to acceptance by the SMA. The SMA will conduct follow-up activities to determine that systems corrections have been achieved and are sustaining.

DSPD Provider Contract - Supervisory Requirements:
A. Incident Reports:
Within 24 hours of any incident requiring a report, the Contractor shall notify both the DHS/DSPD Support Coordinator and the person’s Guardian by phone, email, or fax.

Within five (5) business days of the occurrence of an incident, the Contractor shall complete a DHS/DSPD Form 1-8 Incident Report and file it with the participant's administrative case manager. However, the mandatory reporting requirements of Utah Code § 62-A-3-301 through 321 for adults always take precedence. Therefore, in the case of actual or suspected incidents of abuse, neglect, exploitation, or maltreatment of an adult, the person or administrative case manager shall immediately notify Adult Protective Services intake or the nearest law enforcement agency. The following situations are incidents that require the filing of an incident report with DSPD:
1. Actual or suspected incidents of abuse, neglect, exploitation, or maltreatment per the DHS/DSPD Code of Conduct and Utah Code §§ 62-A-3-301 through 321, which can be found at http://www.le.state.ut.us/~code/TITLE62A/62A03.htm for adults; and, Utah Code §§ 62-4a-401 through 412 for children, which can be found at

http://www.le.state.ut.us/~code/TITLE62A/62A04.htm.
2. Drug or alcohol abuse, medication overdoses or errors reasonably requiring medical intervention,
3. Missing person,
4. Evidence of seizure in a person with no existing seizure diagnosis,
5. Significant property destruction (damage totaling $500.00 or more). Property damage shall be covered by the Contractor's insurance unless it is agreed upon by the person's team that the person shall pay for damages,
6. Physical injury reasonably requiring a medical intervention,
7. Law enforcement involvement,
8. Unless Otherwise prohibited: Any use of manual restraint, mechanical restraints, exclusionary time-out or time-out rooms as defined in Utah Administrative Code, Rule R539-4, and level II emergency interventions not outlined in the person's behavioral plan (e.g., response cost, overcorrection). http://rules.utah.gov/publicat/code/r539/r539.htm
9. Any other instances the Contractor (SC/Case Manager) determines should be reported. After receiving an incident report, the DHS/DSPD administrative case manager shall review the report and decide if further review is warranted.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The administrative case manager provides the participant with information/training on the following topics: (a) how to avoid theft/security issues; (b) maintaining personal safety when recruiting/interviewing potential employees; (c) assertiveness/boundaries/rules with employees; (d) maintaining personal safety when firing an employee; (e) when and how to contact and report instances of abuse, neglect, exploitation; (f) resources on a local level to assist the participant if they are a victim of abuse, neglect or exploitation; and (g) fraud awareness and prevention.

Participant training and education is provided upon enrollment in the waiver and as needed thereafter.

According to Utah Code 76-5-111.
1. As provided in Utah Human Services Code, Aging and Adult Services, 62A3-305:
(1) A person who has reason to believe that a vulnerable adult has been the subject of abuse, neglect, or exploitation shall immediately notify Adult Protective Services intake or the nearest law enforcement agency. When the initial report is made to law enforcement, law enforcement shall immediately notify Adult Protective Services intake. Adult Protective Services and law enforcement shall coordinate, as appropriate, their efforts to provide protection to the vulnerable adult.
(4)(a) A person who willfully fails to report suspected abuse, neglect, or exploitation of a vulnerable adult is guilty of a class B misdemeanor.
(b) A covered provider or covered contractor, as defined in Section 26-21-201, that knowingly fails to report suspected abuse or neglect, as required by this section, is subject to a private right of action and liability for the abuse or neglect of another person that is committed by the

individual who was not reported to Adult Protective Services in accordance with this section.

The State uses the following standard in its evaluation of allegations: "The probability that the incident occurred as a result of the alleged/suspected abuse, neglect and/or exploitation is clear and convincing."

The State does not review incident reports/findings differently when a single provider renders both residential and day services.

In instances where the allegation/incident involved conduct by the Operating Agency, the SMA would conduct the investigation.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Responsibility of the State Medicaid Agency:
After a critical incident/event is reported to the SMA by the Operating Agency, the Operating Agency facilitates the investigation of the incident/event and submits the Critical Incident Findings, Operating Agency Report to SMA to the SMA within two weeks of reporting the incident/event. Cases that are complicated and involve considerable investigation may require additional time to complete the findings document. The SMA reviews the report to determine if the incident could have been avoided, if additional supports or interventions have been implemented to prevent the incident from recurring, if changes to the support plan and/or budget have been made, if any systemic issues were identified and a plan to address systemic issues developed. Participants and/or legal representatives are informed in writing of the investigation results within two weeks of the closure of the case by the SMA.

Responsibility of the Operating Agency: The Office of Licensing will conduct independent state investigations of all critical incidents in regard to licensed providers in accordance with Utah Administrative Code, Rule 501-1-2. Additionally, OL will inform and collaborate with DOH, administrative case managers and OQD whenever an investigation is opened (and concluded) in a DSPD Contracted/Waiver setting.

Administrative case managers and OQD staff are delegated to conduct all unlicensed entities' incident investigations under all of the same guidelines and priority classifications as Licensing Investigations and will work in conjunction with OQD and DOH for all non-licensed programs. I. Critical Incidents Other than incidents specifically outlined in the DHS Incident Reporting Guide 2018, all CIs are detailed and outlined in Office of Licensing Rule. What constitutes a CI is defined specifically in Utah Administrative Code, Rule 501-1-2(9).

Reporting requirements for CIs: Any incident that arises to, or meets the specific definition of a CI, as defined in section I.A. or I.B. shall be reported in accordance with Utah Administrative Code, Rule 501-1-9, unless stated otherwise in this guide.

Rule 501-1-9 states:
(i) report shall be made to DHS and legal guardians of involved clients within one business day;
(A) if the critical incident involves a client or service under a DHS contract, the critical incident report must be completed within 24 hours and may require a five day follow up report to the

involved DHS Division;

(ii) Initial critical incident reports to DHS shall include the following in writing: (A) name of provider and all involved staff, witnesses and clients; (B) date, time, and location of the incident, and date and time of incident discovery, if different from time of incident; (C) descriptive summary of incident; (D) actions taken; and (E) actions planned to be taken by the program at the time of the report. (F) identification of DHS contracts status, if any. (iii) It is the responsibility of the licensee to collect and maintain and submit as requested original witness and participant witness statements and supporting documentation regarding all critical incidents that require individual perspectives to be understood.

D. Process for reporting:
2. In addition, notification of the incident shall also be given to the appropriate case manager, case worker or support coordinator. This may be accomplished via entry into USTEPS when applicable. Although they may conduct follow-up relative to the needs of the client, case managers, case workers or support coordinators shall not independently engage in any investigatory actions or functions relative to an incident reported to them. Investigations of CIs will be conducted by or under the direction of the Office of Licensing.

3. For incidents involving individuals in the DSPD system, CIs shall be reported through USTEPS and shall include any additional information required by that system. OL staff assigned to process and evaluate these incidents will then refer them to the Office of Licensing, if the incident involves a licensee and rises to the level of a CI as defined above.

II. Non-Critical Incidents (only applicable to providers with DHS contracts) Non-Critical Incidents ("NCI") are those events or occurrences that do need to be reported, but do not need to be reported to the Office of Licensing. Reporting requirements or procedures for NCIs are outlined below. In addition, the requirements relating to NCIs only applies to those entities serving a DHS population under a state contract. These do not apply to non-contracted private providers.

A. The following are NCIs that shall be reported: 1. Unexpected hospitalizations that result in admission. This includes any admission to psychiatric facilities. 2. Any destruction of property attributed to an individual receiving services, the value of which exceeds $500.00, unless such behavior is one identified as a target behavior in a Behavior Support Plan and is reported in a monthly behavior summary sent to appropriate case management/support coordination. 3. Suicidal ideation or threats of suicide when the individual does not have services and supports in place to address such behaviors, a description of which are also not being reported on a monthly summary to appropriate case management. 4. Use of emergency behavior interventions as such are defined in Utah Administrative Code Rule 539-4. This is applicable only to people receiving services under the DSPD system. 5. Aspiration or choking which does not result in hospitalization. 6. Evidence of a seizure or seizure like behavior in an individual with no existing seizure diagnosis, except where seizures have been ruled out and seizure like behavior is a behavior identified as a target behavior in a Behavior Support Plan and reported in a monthly behavior summary sent to the appropriate case management/support coordination. 7. Any incident involving the alleged or confirmed waste, fraud or abuse of Medicaid funds by either a provider or a recipient of Medicaid services. 8. Any involvement of an outside entity such as fire department, law enforcement, etc. 9. Attempted escape from a detention or secure facility. 10. Unlawful or unauthorized possession of pornographic material. 11. Any pending litigation that is specifically related to the provider's services or to an individual receiving

services. B. Reporting process and requirements for NCIs:

1. Initial notification shall be made within 24 hours of the incident to the appropriate case manager, case worker or support coordinator. For those serving individuals in the DSPD system, this may be accomplished via entry into USTEPS when applicable. This initial notification shall contain the following information: • Identification of the individual receiving services involved in the incident • The date of the incident • The date the incident was discovered • A brief description of the occurring incident

2. A full report of the incident shall be submitted to the case manager, case worker or support coordinator within 5 business days. This report shall include the following: • The reporting criteria established in Utah Administrative Code, Rule 501-1-9, which are also referenced in section I.C. above. Those providing services to individuals in the DSPD system shall also include any additional criteria set forth in USTEPS.

3. In addition to the initial and full report, providers may be asked to provide additional information if such information is required by DHS, Department of Health or other entity making further inquiry of an incident(s).

In instances where the allegation/incident involved conduct by the Operating Agency, the SMA would conduct the investigation.

The State uses a burden of proof standard in regards to allegations of abuse, neglect or exploitation. (The probability that the incident occurred as a result of the alleged/suspected abuse, neglect and/or exploitation is clear and convincing). In general, the State's incident reporting criteria is event based - if the occurrence of a defined criteria is met, the incident must be reported. The level of investigation/remediation may be altered depending on the severity of incident/likely recurrence/improper safeguards, etc.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

Oversight Responsibility of Critical Incidents/Events of the State Medicaid Agency:

The SMA reviews 100% of critical incident reports, annually. The SMA also reviews the DHS/DSPD annual Incident Report. If the SMA detects systemic problems either through this reporting mechanism or during the SMA's program review process, DHS/DSPD will be requested to submit a plan of correction to the SMA. The plan of correction will include the interventions to be taken and the time frame for completion. All plans of correction are subject to acceptance by the SMA. The SMA will conduct follow-up activities to determine that systems corrections have been achieved and are sustaining.

Oversight Responsibility of Critical Incidents/Events of the Operating Agency:

The operating agency has responsibility for oversight of critical incidents and events. Incident reports are compiled, logged into the UPI/USTEPS electronic database, analyzed and trends are identified. The information is utilized to identify prevention strategies on a system wide basis and identify potential areas for quality improvement.

The DHS/DSPD generates a summary report of the incident reports annually (at minimum) and

submits it to the SMA. During annual chart reviews, State staff reviews for instances where log notes may have indicated a reportable event occurred.

Quarterly reports submitted by the OA are reviewed for Level 2 incidents. Level 1 incidents are reported to the SMA upon notification to the OA.

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

a. Use of Restraints ***(select one):(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)***

X	**The State does not permit or prohibits the use of restraints** Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:
	The SMA has established a Critical Incident/Event notification system as described in Appendix G-1(b) that requires DSPD to notify the SMA of any serious incidents including the use of restraints that are reported as part of critical incident notifications. DSPD also verifies that there is no use of restraints when conducting on site visits and performing annual reviews. Any incidents involving the use of restraints would be immediately reported to Adult Protective Services. Administrative case managers have the day to day responsibility to assure that there are no incidents involving the use of restraints.
✦	**The use of restraints is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii:

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

b. Use of Restrictive Interventions

X	**The State does not permit or prohibits the use of restrictive interventions** Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:
	The SMA has established a Critical Incident/Event notification system as described in Appendix G-1(b) that requires DSPD to notify the SMA of any serious incidents including the use of restrictive interventions that are reported as part of critical incident notifications. DSPD also verifies that there is no use of restrictive interventions when conducting on site

	visits and performing annual reviews. Any incidents involving the use of restrictive interventions would be immediately reported to Adult Protective Services. Administrative case managers have the day to day responsibility to assure that there are no incidents involving the use of restrictive interventions.
✦	**The use of restrictive interventions is permitted during the course of the delivery of waiver services.** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

c. Use of Seclusion. *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

X	**The State does not permit or prohibits the use of seclusion** Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:
	The SMA has established a Critical Incident/Event notification system that requires DSPD to notify the SMA of any serious incidents including the use of seclusion reported as part of critical incident notifications. DSPD also verifies that there is no use of seclusion when conducting on site visits and performing annual reviews. Any incidents involving the use of seclusion would be immediately reported to Adult Protective Services. Administrative case managers have the day to day responsibility to assure that there are no incidents involving the use of seclusion.
✦	**The use of seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G-3: Medication Management and Administration

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

X	**No**. **This Appendix is not applicable** *(do not complete the remaining items)*
✦	**Yes**. **This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and (c) the State agency (or agencies) that is responsible for follow-up and oversight.

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one*:

✦	Not applicable (*do not complete the remaining items*)
✦	**Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

State:	
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State:	
Effective Date	

iii. Medication Error Reporting. *Select one of the following:*

✦	**Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).** *Complete the following three items:*
	(a) Specify State agency (or agencies) to which errors are reported:
	(b) Specify the types of medication errors that providers are required to *record:*
	(c) Specify the types of medication errors that providers must *report* to the State:
✦	**Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.** Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Health and Welfare**
The State demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.

i. Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.

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For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure: #2	*Number and percentage of incidents involving abuse, neglect and exploitation of waiver participants where recommended actions to protect health and welfare were implemented. The numerator is the total number of reported incidents where recommended actions to protect health and welfare were implemented; the denominator is the total number of incidents requiring safeguards.*		
Data Source *Incident Reports*	*Responsible Party for data collection/generation (check each that applies)*	*Frequency of data collection/generation: (check each that applies)*	*Sampling Approach (check each that applies)*
	☐ State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error*
	☐ Other: Specify:	*☐ Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Groups*
		☐ Other: Specify:	
			☐ Other: Describe
Data Aggregation and Analysis	*Responsible Party for data aggregation and*	*Frequency of data aggregation and*	

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Effective Date	

	analysis (check each that applies	*analysis: (check each that applies*	
	X State Medicaid Agency	*☐ Weekly*	
	X Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	*☐ Annually*	
		☐ Continuously and Ongoing	
		X Other: Specify: Every two years	

Performance Measure: #3	*Number and percentage of waiver participant deaths for which the Department of Human Services' Fatality Review Committee process was followed. The numerator is the total number of waiver participant deaths for which the Department of Human Services' Fatality Review Committee process was followed; the denominator is the total number of waiver participant deaths.*		
Data Source *USTEPS*	*Responsible Party for data collection/generation (check each that applies)*	*Frequency of data collection/generation: (check each that applies)*	*Sampling Approach (check each that applies)*
	☐ State Medicaid Agency	*☐ Weekly*	*X 100% Review*
	X Operating Agency	*☐ Monthly*	*☐ Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*☐ Representative Sample; Confidence Interval*
	☐ Other: Specify:	*☐ Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Groups*
		☐ Other: Specify:	
			☐ Other: Describe

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Effective Date	

Data Aggregation and Analysis	*Responsible Party for data aggregation and analysis (check each that applies*	*Frequency of data aggregation and analysis: (check each that applies*	
	X State Medicaid Agency	*☐ Weekly*	
	X Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	*X Annually*	
		☐ Continuously and Ongoing	
		☐ Other: Specify:	

***Performance Measure:* #1**	**Number and percentage of suspected abuse, neglect and exploitation incidents referred to Adult Protective Services and/or law enforcement as required by State law.** The numerator is the total number of incidents reported correctly; the denominator is the total number of reported incidents reviewed involving suspected abuse, neglect and/or exploitation.		
Data Source **USTEPS** **Incident Reports** **DSPD Annual Incident Report**	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	✗ *State Medicaid Agency*	✗ *Weekly*	✗ *100% Review*
	X *Operating Agency*	✗ *Monthly*	**X** *Less than 100% Review*
	✗ *Sub-State Entity*	✗ *Quarterly*	**X** *Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error*
	✗ *Other: Specify:*	✗ *Annually*	
		X *Continuously and Ongoing*	✗ *Stratified: Describe Groups*

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Effective Date	

		✗ *Other: Specify:*	
			✗ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	X *State Medicaid Agency*	✗ *Weekly*	
	X *Operating Agency*	✗ *Monthly*	
	✗ *Sub-State Entity*	✗ *Quarterly*	
	✗ *Other: Specify:*	✗ *Annually*	
		✗ *Continuously and Ongoing*	
		X *Other: Specify:* Every two years	

Performance Measure: #1	*# and % of abuse, neglect, exploitation and unexpected death incidents reported to DSPD within 24 hours of discovery of occurrence. Numerator is total number of abuse, neglect, exploitation and unexpected death incidents reviewed reported to DSPD within 24 hours of the discovery of occurrence; denominator is the total number of abuse, neglect, exploitation and unexpected death incidents reviewed.*		
Data Source *USTEPS* *Incident Reports* *DSPD Annual Incident Report*	*Responsible Party for data collection/generation (check each that applies)*	*Frequency of data collection/generation: (check each that applies)*	*Sampling Approach (check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	*X 100% Review*
	X Operating Agency	☐ *Monthly*	*Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	*X Representative Sample; Confidence Interval = 95% Confidence Level,*

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Effective Date	

			5% Margin of Error
	☐ Other: Specify:	*☐ Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Groups*
		☐ Other: Specify:	
			☐ Other: Describe
Data Aggregation and Analysis	*Responsible Party for data aggregation and analysis (check each that applies*	*Frequency of data aggregation and analysis: (check each that applies*	
	X State Medicaid Agency	*☐ Weekly*	
	X Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	*☐ Annually*	
		☐ Continuously and Ongoing	
		X Other: Specify: Every two years	

Performance Measure: #1	*# and % of abuse, neglect, exploitation & unexpected death incidents for which providers submit incident report in 5 business days of discovery of incident. Numerator is total # of incidents reviewed for which providers submit incident report in 5 business days of discovery of incident; Denominator is total number of abuse, neglect, exploitation & unexpected death incidents reviewed.*		
Data Source *USTEPS* *Incident Reports* *DSPD Annual Incident Report*	*Responsible Party for data collection/generation (check each that applies)*	*Frequency of data collection/generation: (check each that applies)*	*Sampling Approach (check each that applies)*

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Effective Date	

	☐ *State Medicaid Agency*	☐ *Weekly*	*X 100% Review*
	X Operating Agency	☐ *Monthly*	*Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	*X Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error*
	☐ *Other: Specify:*	☐ *Annually*	
		X Continuously and Ongoing	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
Data Aggregation and Analysis	*Responsible Party for data aggregation and analysis (check each that applies*	*Frequency of data aggregation and analysis: (check each that applies*	
	X State Medicaid Agency	☐ *Weekly*	
	X Operating Agency	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		X Other: Specify: Every two years	

ii. Sub-assurance: The State demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

***Performance Measure:* #1**	*Number and percentage of quarterly critical incident reports submitted to the SMA which demonstrate how incident data are collected, compiled, and used to prevent re-occurrence. The numerator is the number of reports which demonstrate how incident data are collected, compiled, and used to prevent re-occurrence; the denominator is the total number of reports required.*		
Data Source **USTEPS** **Incident reports**	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	✗ *State Medicaid Agency*	✗ *Weekly*	*X 100% Review*
	X *Operating Agency*	✗ *Monthly*	✗ *Less than 100% Review*
	✗ *Sub-State Entity*	✗ *Quarterly*	✗ *Representative Sample;*
	✗ *Other: Specify:*	✗ *Annually*	
		X *Continuously and Ongoing*	✗ *Stratified: Describe Groups*
		✗ *Other: Specify:*	
			✗ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	X *State Medicaid Agency*	✗ *Weekly*	
	X *Operating Agency*	✗ *Monthly*	
	✗ *Sub-State Entity*	✗ *Quarterly*	

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	✗ *Other: Specify:*	✗ *Annually*	
		✗ *Continuously and Ongoing*	
		X *Other: Specify:* Every two years	

Performance Measure: #2	***Number and percentage of critical incident trends identified for systemic intervention that were implemented. The numerator is the number of trends where systemic intervention was implemented; the denominator is the total number of critical incident trends.***		
Data Source **USTEPS** **Incident Reports**	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	✗ *State Medicaid Agency*	✗ *Weekly*	*X 100% Review*
	X *Operating Agency*	✗ *Monthly*	✗ *Less than 100% Review*
	✗ *Sub-State Entity*	✗ *Quarterly*	✗ *Representative Sample;*
	✗ *Other: Specify:*	✗ *Annually*	
		X *Continuously and Ongoing*	✗ *Stratified: Describe Groups*
		✗ *Other: Specify:*	
			✗ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	X *State Medicaid Agency*	✗ *Weekly*	
	X *Operating Agency*	✗ *Monthly*	
	✗ *Sub-State Entity*	✗ *Quarterly*	
	✗ *Other: Specify:*	✗ *Annually*	
		✗ *Continuously and Ongoing*	
		X *Other: Specify: Every two years*	

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iii. Sub-assurance: The State policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

***Performance Measure:* #1**	***# & % incidents identifying unauthorized use of restrictive interventions (including restraints/seclusion) appropriately reported, investigated & for which recommended follow-up was completed. Numerator is total # of these types of incidents reviewed that were appropriately reported, investigated and had recommended follow-up; Denominator is total # of these types of incidents.***		
Data Source **USTEPS**	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	✗ *State Medicaid Agency*	✗ *Weekly*	✗*100% Review*
	X *Operating Agency*	✗ *Monthly*	**X** *Less than 100% Review*
	✗ *Sub-State Entity*	✗ *Quarterly*	**X** *Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error*
	✗ *Other: Specify:*	✗ *Annually*	
		X *Continuously and Ongoing*	✗ *Stratified: Describe Groups*
		✗ *Other: Specify:*	
			✗ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that*	***Frequency of data aggregation and analysis:*** *(check each that*	

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	applies	*applies*	
	X *State Medicaid Agency*	✗ *Weekly*	
	X *Operating Agency*	✗ *Monthly*	
	✗ *Sub-State Entity*	✗ *Quarterly*	
	✗ *Other: Specify:*	✗ *Annually*	
		✗ *Continuously and Ongoing*	
		X *Other: Specify: Every two years*	

iv. Sub-assurance: The State establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

***Performance Measure:* #1**	*Number and percent of participants whose Person Centered Support Plan (PCSP) addresses their health needs. Numerator = Number of participants whose PCSP addresses their health needs. Denominator = Number of PCSPs reviewed.*		
Data Source ● **USTEPS**	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	✗ *State Medicaid Agency*	✗ *Weekly*	✗ *100% Review*
	X *Operating Agency*	✗ *Monthly*	**X** *Less than 100% Review*
	✗ *Sub-State Entity*	✗ *Quarterly*	**X** *Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error*

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	✗ *Other: Specify:*	✗ *Annually*		
		✗ *Continuously and Ongoing*		✗ *Stratified: Describe Groups*
		X *Other: Specify: Every two years*		
				✗ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*		
	✗ *State Medicaid Agency*	✗ *Weekly*		
	X *Operating Agency*	✗ *Monthly*		
	✗ *Sub-State Entity*	✗ *Quarterly*		
	✗ *Other: Specify:*	✗ *Annually*		
		✗ *Continuously and Ongoing*		
		X *Other: Specify: Every two years*		

v. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

Referrals are made to Adult Protective Services and/or law enforcement according to State laws. Prevention strategies are developed and implemented when abuse, neglect or exploitation are reported. Health and welfare needs are addressed and steps are taken to resolve concerns in a timely manner and are documented in the record. In most cases, face to face visits are conducted to verify that all concerns are resolved. The SMA Quality Assurance Team conducts monitoring when notified by DSPD of a Level I critical incident or event.

The DHS/DSPD conducts formal reviews of critical incidents at a minimum of every two years. When a fatality occurs, the Fatality Review Committee (Committee) reviews the death and submits a written report to the DSPD Director (Director). If follow-up is required, DSPD and its Director will respond to Committee accordingly.

The SMA conducts annual and periodic reviews of the PD Waiver program. At a minimum, one comprehensive review will be conducted during the five year waiver cycle.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.*

Individual issues identified that affect the health and welfare of individual participants are addressed immediately. These issues are addressed in a variety of ways, and may include: a) direct contact for additional information if any, and b) informal discussion or formal (written) notice of adverse findings. The SMA will use discretion in determining notice requirements depending on the findings. Examples of issues requiring intervention by the SMA would include: overpayments; allegations or substantiated violations of health and safety; necessary involvement of APS and/or local law enforcement; or issues involving the State's Medicaid Fraud Control Unit.

To assure the issue has been addressed, DSPD is required to report back to the SMA on the results of their interventions within designated time frames. These time frames are outlined in standard operating procedures or protocols or are stipulated on a case by case basis depending on the nature of a specific issue. A description of issues requiring immediate attention and outcomes are documented through the SMA Final Report.

Issues that are less immediate are corrected within designated time frames and are also documented through the SMA Final Report. When the SMA determines that an issue is resolved, notification is provided and documentation is maintained.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	***Responsible Party*** *(check each that applies)*	***Frequency of data aggregation and analysis:*** *(check each that applies)*
	X *State Medicaid Agency*	✗ *Weekly*
	X *Operating Agency*	✗ *Monthly*
	✗ *Sub-State Entity*	✗ *Quarterly*
	✗ *Other: Specify:*	✗ *Annually*
		✗ *Continuously and Ongoing*
		X Other: Specify: Every two years

State:	
Effective Date	

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

✦	**Yes** *(complete remainder of item)*
X	**No**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

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Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I), a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The remediation activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

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H.1 Systems Improvement

a. **System Improvements**

i. Describe the process(es) for trending, prioritizing and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

Trending is accomplished as part of the SMA annual waiver review for each performance measure that is assessed that year. Graphs display the percentage of how well the performance measures are met for each fiscal year. Graphs from the previous years are presented side by side with the current year's results, thus allowing for tracking and trending of performance measures. After a three-year cycle of reviews (and annually thereafter), the performance measures will be analyzed to determine if, over time, a negative trend has occurred and if a systems improvement will address the problem. System improvement initiatives may be prioritized based on several factors including the health and welfare of participants, financial considerations, the intensity of the problem and the other performance measures relating to assurance being evaluated.

Additionally, a Quality Improvement Committee which includes representation from the SMA, the Division of Services for People with Disabilities, the Office of Quality and Design, and the Division of Licensing meets at least monthly to review discovery and remediation information, analyze that information, recommend system improvements, and analyze the effectiveness of the improvement initiatives. The Committee may generate or request quality improvement reports to monitor outcomes, evaluate the effectiveness of process and system improvements, and track and trend performance measures. Quality improvement reports which include the above information are compiled at a minimum of annually, more frequently as necessary, or in accordance with the Quality Improvement Plan for any performance measure with a rate of compliance below 86%. The Committee maintains an accountability tracker to assure designated research and reporting tasks assigned to each agency are completed as required.

ii. System Improvement Activities

Responsible Party *(check each that applies):*	**Frequency of monitoring and analysis** *(check each that applies):*
X State Medicaid Agency	**☒ Weekly**
X Operating Agency	**☒ Monthly**
☒ Sub-State Entity	**☒ Quarterly**
X Quality Improvement Committee	**X Annually**
☒ Other Specify:	**X Other** Specify:
	Third year of waiver operation

State:	
Effective Date	

b. **System Design Changes**

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The SMA will establish a Quality Improvement Committee consisting of the SMA Quality Assurance Team, the DSPD waiver manager, the DSPD Quality Team, the Office of Quality and Design, and the Division of Licensing, among others. The team will meet to assess the results of the systems design changes. The success of the systems changes will be based on criteria that must be met to determine that the change has been accomplished and also criteria that will determine that the systems change has been sustained or will be sustained. The Quality Improvement Committee will determine the sustainability criteria. Results of system design changes will be communicated to participants and families, providers, agencies and others through the Medicaid Information Bulletin, the DSPD web site, and DSPD Board Meetings.

The Quality Improvement Committee utilizes data from quarterly and/or annual quality improvement reports to review findings and inform the development of any necessary Quality Improvement Plans. System improvement initiatives may be prioritized based on several factors including the health and welfare of participants, financial considerations, the intensity of the problem and the other performance measures relating to assurance being evaluated. All members of the Quality Improvement Committee can support the development of strategies to improve outcomes; action items are assigned to appropriate agency representatives in the accountability tracker to ensure research is conducted and strategies are fully developed in accordance with Committee timelines and expectations. The Committee assesses the effectiveness of system improvements through the review of quality improvement reports at a minimum of quarterly, more frequently as necessary, or in accordance with the Quality Improvement Plan for any performance measure with a rate of compliance below 86%.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Quality Improvement Strategy is dynamic and is continuously evaluated each year by the SMA's quality management team. The team evaluates the data collection process and makes changes as necessary to allow for accurate data collection and analysis. In addition, the Quality Improvement Committee will evaluate the QIS after the third year of the waiver operation. This committee will meet to discuss the elements of the QIS for each assurance, the findings relative to each performance measure and the contributions of all parties that conduct quality assurance of the PDW waiver. Improvements to the QIS will be made at this time and submitted in the following waiver renewal application.

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Appendix I: Financial Accountability

APPENDIX I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as CMS may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.

The State conducts a single audit in conformance with the Single Audit Act of 1984, Public Law 98-502.

DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES ROLE AND PROVIDER CONTRACTING REQUIREMENT

The Division of Services for People with Disabilities (DSPD) is the designated State agency responsible for planning and developing an array of services and supports for persons with disabilities living in Utah. State statute 62A-5-103, 1953 as amended, sets forth DSPD's authority and responsibility to:

1. Plan, develop and manage an array of services and supports for individuals with disabilities;
2. Contract for services and supports for persons with disabilities;
3. Approve, monitor and conduct certification reviews of approved providers; and
4. Develop standards and rules for the administration and operation of programs operated by or under contract with DSPD.

In accordance with DSPD's lead role and designated responsibilities, monies allocated for services for persons with disabilities are appropriated by the State Legislature to DSPD which in turn contracts with public and private providers for the delivery of services. To assure the proper accounting for State funds, DSPD enters into a written State contract with each provider. This State-specific requirement applies regardless of whether: 1) the State funds are used for State-funds only programs or are used to draw down FFP as part of a 1915(c) HCBS Waiver program, or 2) the target population includes Medicaid-eligible citizens. The State contract is the sole responsibility of, and is managed by, DSPD's parent agency, the Department of Human Services.

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In the case where a portion of the annual Legislative appropriation is designated for use as State matching funds for the Medicaid 1915(c) HCBS Waiver described herein, DSPD certifies to the State Medicaid Agency (SMA), through an interagency agreement, that the State funds will be transferred to the SMA in the amount necessary to reimburse the State match portion of projected Medicaid expenditures paid through the MMIS system for waiver services.

As a result of the State's organizational structure described above:

1. All providers participating in this 1915(c) HCBS PD Waiver must: a) Fulfill the DSPD State contracting requirement as one of the waiver provider qualifications related to compliance with State law, and b) agree to bill the MMIS directly or voluntarily reassign payment to DHS/DSPD.
2. The State Medicaid Agency reimburses DSPD for any interim payments that are made for legitimate waiver service claims during the time the clean claim is being processed through the MMIS system.
3. The State Medicaid Agency receives from DSPD the State matching funds associated with the waiver expenditures prior to the State Medicaid Agency's drawing down Federal funds.
4. The State Medicaid Agency approves all proposed rules, policies and other documents related to 1915(c) waivers prior to adoption by the DSPD policy board.

SMA ROLE AND PROVIDER CONTRACT REQUIREMENT

The SMA, in fulfillment of its mandated authority and responsibilities related to the 1915(c) HCBS waiver programs, retains responsibility for negotiating a Medicaid Provider Agreement with each provider of waiver services. Unlike the DSPD State contract required of all providers of services to persons with disabilities who receive State monies, the Medicaid Provider Agreement is specific to providers of Medicaid funded services.

DHS/DSPD requires submission of all mandatory State Audit requirements imposed on contracted providers by the State Auditor's Office. This information is a requirement of the contract entered into by DSPD and the provider.

During annual contract reviews, the DHS Quality Management team reviews 100% of provider contracts. A component of the reviews includes a review of payment histories and the documentation to support those payments. This ensures the services were received and the correct payment was made.
The Quality Management team at DHS selects two months of data during the past year and compares claims data with supporting documentation at the provider site (attendance records, time sheets, progress notes, etc.) for each client in the sample. If the reviewer notes inconsistencies, an expanded review may be completed. This may involve the expansion of the date range of information for a particular client, or additional clients to be added to the sample. As part of provider reviews, while 100% of providers are reviewed, 10% of the individuals served by that provider are reviewed. The claims belonging to the specific provider, for that individual will be reviewed.

Review results are communicated to providers through a draft report of findings. The provider is then given an opportunity to supply evidence to refute the findings cited. Should evidence be supplied, it is considered by the SMA/OA prior to a final report being completed.

When overpayments or other ineligible claims are identified by the OA, the OA works with the SMA to return FFP amounts. The SMA receives the results of all audits performed including the initial presentation of findings to providers (which may include the identification of ineligible payments).

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These communications include instructions for the provider on how they may refute or accept the findings, and in the case of ineligible payments, how they may return funds to the OA or appeal the decision.

Providers are required to develop plans of correction when deficiencies are cited. Should a plan of correction be required by the provider, it is reviewed and approved prior to being implemented. During subsequent reviews, verification of items within the plan are reviewed. Should non-compliance continue, an expanded review may be completed, or a more aggressive plan may be required with more frequent reviews.

OA provider contract reviews are conducted separately from post-payment audits completed by the Medicaid agency.

Entities such as DOH Internal Audit, State Office of Inspector General (OIG), Federal OIG, Office of Legislative Auditor General, Medicaid Fraud Control Unit, etc. may engage in additional review activities at their discretion.

Medicaid recipients are to be contacted by their administrative case managers monthly to ensure that service delivery has been in accordance with the amount/frequency/duration listed on their support plans. Administrative case managers are then responsible for either allowing provider payments to be processed or identify any questionable requests for payment to the OA.

JOINT DSPD STATE CONTRACT/SMA PROVIDER AGREEMENT

Personal Attendant providers present challenges to the effective and efficient operation of the PD Waiver in particular. It is anticipated that this will be the sole instance in which individuals serving as Personal Attendants will be associated with the Medicaid program as enrolled providers. It is also anticipated that the number of participating Personal Attendants will be significant, thus imposing a substantial administrative effort to negotiate required contracts and agreements. Therefore, for purposes of the effective management of Personal Attendant waiver service providers only, a joint DSPD State Contract/SMA Provider Agreement (Joint Agreement) has been developed. The Joint Agreement complies with the content requirements of the Medicaid Provider Agreement and requires the signature of the Personal Attendant waiver service provider, DSPD, and the SMA. The effective date of the contract is the date the document is signed by all three parties.

Upon enrollment into the PD Waiver all individuals receiving services through the self-administered services method are informed of their responsibility and sign a letter of agreement to monitor and manage all employee(s) hours and wages. They are required to receive, sign and copy all employee(s) timesheets and submit them to the FMS agent twice a month. The participant is responsible to verify the accuracy of all hours billed by the employee(s).

Each month the administrative case manager reviews the billing statement and a monthly budget report generated by DSPD.

INTERAGENCY AGREEMENT FOR OPERATIONS AND ADMINISTRATION OF THE HCBS WAIVER

An interagency agreement between the SMA and DSPD sets forth the respective responsibilities for the administration and operation of this waiver. The agreement delineates the SMA's overall responsibility to provide management and oversight of the waiver including review and approval of all waiver related rules and policies to ensure compliance with Medicaid HCBS waiver rules and

regulations. The agreement also delineates DSPD's roles in relation to the statutory responsibilities to develop the State's program for persons with disabilities. The nature of the agreement enhances provider access to the Medicaid program and quality assurance of services as well as defines the fiscal relationship between the two agencies.

The major components of the agreement are:

1. Purpose and Scope;
2. Authority;
3. Definitions;
4. Waiver Program Administration and Operation Responsibilities;
5. Claims Processing;
6. Payment for Delegated Administrative Duties (including provisions for State match transfer);
7. Role Accountability and FFP Disallowances; and
8. Coordination of DHS Policy Development as it relates to Implementation of the Medicaid Program.

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Financial Accountability Assurance**
The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program

i. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure: #4	*# & % of recoupments in a rep sample of participants which are identified & processed correctly through MMIS & have an audit trail*

	of the TCN in error showing overpayments are returned to the fed gov within required timeframes. N=total # of recoupments for participants sampled which were identified, processed, & returned correctly; D=total # of recoupments identified in the participant sample		
Data Source ● *Participant Claims Data* ● *SMA QA Review* ● *CMS 64 Report*	*Responsible Party for data collection/generation (check each that applies)*	*Frequency of data collection/generation: (check each that applies)*	*Sampling Approach (check each that applies)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	☐ Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error*
	☐ Other: Specify:	*X Annually*	
		☐ Continuously and Ongoing	*☐ Stratified: Describe Groups*
		☐ Other: Specify:	
			☐ Other: Describe
Data Aggregation and Analysis	*Responsible Party for data aggregation and analysis (check each that applies*	*Frequency of data aggregation and analysis: (check each that applies*	
	X State Medicaid Agency	*☐ Weekly*	
	☐ Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	*X Annually*	
		☐ Continuously and	

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		Ongoing	
		☐ Other: Specify:	

Performance Measure: #1	*Number and percentage of paid claims in a representative sample of participants for services that use approved waiver codes and rates. The numerator is the total number of paid claims in the participant sample for services that use approved waiver codes and rates; the denominator is the total number of paid claims in the participant sample.*		
Data Source ● *Participant Claims Data* ● *PCSP* ● *Participant Budgets*	*Responsible Party for data collection/generation (check each that applies)*	*Frequency of data collection/generation: (check each that applies)*	*Sampling Approach (check each that applies)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval 95% Confidence Level, 5% Margin of Error*
	☐ Other: Specify:	*X Annually*	
		☐ Continuously and Ongoing	*☐ Stratified: Describe Groups*
		☐ Other: Specify:	
			☐ Other: Describe
Data Aggregation and Analysis	*Responsible Party for data aggregation and analysis (check each that applies*	*Frequency of data aggregation and analysis: (check each that applies*	
	X State Medicaid	*☐ Weekly*	

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	Agency		
	X Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	*☐ Annually*	
		☐ Continuously and Ongoing	
		X Other: Specify: Every two years.	

***Performance Measure:* #1**	*Number and percentage of paid claims in a representative sample of participants for services identified on a participant's service plan which in total do not exceed their annual budget. The numerator is the total number of paid claims in the participant sample which did not exceed the annual budget; the denominator is the total number of paid claims in the participant sample.*		
Data Source ● **Participant Claims Data** ● **PCSP** ● **Participant Budgets**	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X *State Medicaid Agency*	*✗ Weekly*	*✗ 100% Review*
	X *Operating Agency*	*✗ Monthly*	**X** *Less than 100% Review*
	✗ Sub-State Entity	*✗ Quarterly*	X *Representative Sample; Confidence Interval 95% Confidence Level, 5% Margin of Error*
	✗ Other: Specify:	**X** *Annually*	
		✗ Continuously and Ongoing	*✗ Stratified: Describe Groups*
		✗ Other: Specify:	
			✗ Other: Describe

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Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	X *State Medicaid Agency*	✗ *Weekly*	
	X *Operating Agency*	✗ *Monthly*	
	✗ *Sub-State Entity*	✗ *Quarterly*	
	✗ *Other: Specify:*	✗ *Annually*	
		✗ *Continuously and Ongoing*	
		X *Other: Specify:* Every two years	

***Performance Measure:* #2**	*# & % of provider claims submitted and processed through the CAPS in a representative sample of participants which match the DSPD claims submitted and processed through the MMIS. N = total number of provider claims in the participant sample which match in CAPS and MMIS; D = total number of provider claims submitted and processed through CAPS in the participant sample.*		
Data Source ● **Participant Claims Data** ● **PCSP** ● **Participant Budgets**	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X *State Medicaid Agency*	✗ *Weekly*	✗ *100% Review*
	X *Operating Agency*	✗ *Monthly*	**X** *Less than 100% Review*
	✗ *Sub-State Entity*	✗ *Quarterly*	**X** *Representative Sample; Confidence Interval 95% Confidence Level, 5% Margin of Error*
	✗ *Other: Specify:*	**X** *Annually*	
		✗ *Continuously and Ongoing*	✗ *Stratified: Describe Groups*

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		✗ *Other: Specify:*		
				✗ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*		
	X *State Medicaid Agency*	✗ *Weekly*		
	X *Operating Agency*	✗ *Monthly*		
	✗ *Sub-State Entity*	✗ *Quarterly*		
	✗ *Other: Specify:*	✗ *Annually*		
		✗ *Continuously and Ongoing*		
		X *Other: Specify: Every two years*		

ii. Sub-assurance: The State provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure: #2	*Number and percentage of maximum allowable rates (MARs) for covered Waiver services which are consistent with the approved rate methodology. The numerator is the total number of MARs which are consistent with the approved rate methodology; the denominator is the total number of MARs for covered waiver services.*		
Data Source • **CAPS claims payment history**	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*

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report ● **MMIS claims payment history report** ● **Provider Claims**			
	X *State Medicaid Agency*	✗ *Weekly*	✗ *100% Review*
	X *Operating Agency*	✗ *Monthly*	**X** *Less than 100% Review*
	✗ *Sub-State Entity*	✗ *Quarterly*	**X** *Representative Sample; Confidence Interval = 95% Confidence Level, 5% Margin of Error*
	✗ *Other: Specify:*	**X** *Annually*	
		✗ *Continuously and Ongoing*	✗ *Stratified: Describe Groups*
		✗ *Other: Specify:*	
			✗ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	X *State Medicaid Agency*	✗ *Weekly*	
	✗ *Operating Agency*	✗ *Monthly*	
	✗ *Sub-State Entity*	✗ *Quarterly*	
	✗ *Other: Specify:*	✗ *Annually*	
		✗ *Continuously and Ongoing*	
		X *Other: Specify: Every two years.*	

iii. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

The SMA conducts a supplemental review of the PD Waiver performance measures following evaluation of the OA for each of the five waiver years. Due to available resources, at a

minimum one comprehensive review will be conducted during this five year cycle. The comprehensive review will include participant and provider interviews. The other annual reviews will be focused reviews. The criteria for the focused reviews will be determined from DSPD and SMA review findings as well as other issues that develop during the review year. The sample size for each review will be sufficient to provide a confidence level equal to 95% and a confidence interval equal to five.

Contract analysts from DSPD will monitor monthly usage of approved services to ensure that billed services are within the participant's budget. Adjustments will be made to the service plan and budgets when warranted by changes in participant needs. The Utah Systems for Tracking Eligibility, Planning, and Services (USTEPS) will assist with preventing overpayments that are over and above a participant's individual budget by providing reports to administrative case managers to review when claims are either significantly under or over budget.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.*

Recoupment of Funds:

• When payments are made for services not identified on the PCSP: The SMA will require a recoupment of unauthorized paid claims.

• When the amount of payments made exceed the amount identified on the annual budget: The SMA will require a recoupment of unauthorized paid claims.

• When payments are made for services based on a coding error: The coding error will be corrected by withdrawing the submission of the claim and submitting the correct code for payment.

The recoupment of funds will proceed as follows:

1. The SMA will complete a Recoupment of Funds Form that indicates the amount of the recoupment and send it to DSPD.

2. DSPD will review the Recoupment of Funds Form and return the signed form to the SMA.

3. Upon receipt of the Recoupment of Funds Form, the SMA will submit the recoupment to Medicaid Operations.

4. Medicaid Operations will reprocess the MMIS claims to reflect the recoupment.

5. Overpayments are returned to the Federal government within required time frames.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	***Responsible Party*** *(check each that applies)*	***Frequency of data aggregation and analysis:*** *(check each that applies)*
	X *State Medicaid Agency*	✗ *Weekly*
	X *Operating Agency*	✗ *Monthly*
	✗ *Sub-State Entity*	✗ *Quarterly*
	✗ *Other: Specify:*	*X Annually*
		✗ *Continuously and Ongoing*
		✗ *Other: Specify:*

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

✦	**Yes** *(complete remainder of item)*
X	**No**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

APPENDIX I-2: Rates, Billing and Claims

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

There are four principal methods used in setting the DHS Maximum Allowable Rate level. Each method is designed to determine a fair market rate. Four different methodologies are in place to accommodate the different market factors that exist for different types of services. With all new services and any inflationary increases or decreases to existing service rates, the SMA reviews and approves all proposed rates prior to the rates being loaded into the MMIS. Payment rates may also be subject to changes mandated by the State Legislature.

Adjustments to the following processes may be deemed necessary on occasion to comply with funding requirements. Additionally, the process may be adjusted on occasion to account for common factors such as the geographical location of service delivery, absentee factors or division budget constraints, etc. The consideration of geographical location and its effect on rates would be primarily to adjust payment amounts should access to care issues arise in rural areas. Depending on the service, providers may experience increased cost in delivering services due to a waiver participant's proximity to urban centers.

1. Existing Market Survey or Cost Survey of Current Providers.

This methodology surveys existing providers to determine their actual cost to render a service. This would include direct labor, supervision, administration, non-labor costs allocated to the purchased service and the basis of cost allocations. The surveys are designed to assure all providers are reporting costs in a standardized manner and within allowable cost parameters established by DHS. Surveys are examined to determine if cost definitions, allocations and reporting are consistent among respondents and accurately include reasonable costs of business. The rate is set using a measure of central tendency such as median, mode or weighted average and adjusted if necessary to reflect prevailing market conditions. (For example, a large provider may distort data and smaller providers may have substantially different costs. Failure to adjust for market realities may result in lack of available providers if the rate is set too low, or unnecessarily paying too much if the rate is set too high.)

2. Component Cost Analysis

The estimated cost of each of the various components of a service code (rent, treatment, administration, direct labor, non-labor costs allocated to the service, etc.) are determined and added together to determine a provisional rate. This method is often used for a new or substantially modified service that does not currently exist in the marketplace. Provisional rates are designed to determine a fair market rate until historical data becomes available. At a later date when historical cost data does become available a market survey may be undertaken to confirm or adjust the rate.

3. Comparative Analysis

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This method may be used when similar services exist. Adjustments are made to reflect any differences in a new service. Where possible, and to provide consistency of payments in the provider community, rates are set to maintain common rates for common services purchased by various agencies. If a proposed service duplicates an existing service being used by another agency or program, the existing rate may be used to provide consistency of payments in the provider community if the companion agency rate is considered to be in line with the market.

4. Community Price Survey

Where a broad based market exists for a service outside of DHS, existing service providers may be surveyed to determine the prevailing market price for the service. Again, measures of central tendency such as median, mode or weighted average are used and adjusted if necessary to reflect prevailing market.

Payment rates are made available to participants so that they can make informed choices regarding their self-administered services in two ways: 1) Administrative case managers provide payment rate information to participants during their enrollment in self-administered services; and 2) Annually, DSPD sends an approved payment rate letter to the FMS providers. The FMS providers then communicate this information to all participants they serve.

The method used to establish the rate for each waiver service is provided below, along with information regarding how the service is reimbursed to the provider:

Financial Management Services - Comparative Analysis - Fixed/Predetermined
Personal Assistance Services - Comparative Analysis - Fixed/Predetermined - based on State plan Personal Care reimbursement.

Personal Emergency Response System (PERS) (All service variations- Purchase, Rental and Repair; Installation, Testing and Removal; Monthly Response Center Service) - Existing Market Survey - Fixed/Predetermined - MAR was set in FY14 following a provider cost survey – amount was decided to reasonably include all available/willing providers. The State solicited cost information from existing providers as well as other known providers in the industry and requested information on the cost associated with each individual service. Specialized Medical Equipment and Supplies - Community Price Survey - Fixed/Predetermined - MAR was set in FY13 following a provider cost survey – amount was decided to reasonably include all available/willing providers.

The following rates are paid based on the invoiced amount for the service:
- Personal Emergency Response Systems
- Specialized Medical Equipment, and
- Non-Medical Transportation (Bus Pass / UTA)

There are caps on the 'invoiced charge' codes and also a process to evaluate the request for appropriateness including multiple bids, verification that the good/service cannot be paid through other payers (Medicare, State Plan, TPL, etc.) and that lower cost alternatives have been explored prior to paying through the waiver.

The Financial Management Service is tied to existing rates in other programs within the State. Financial Management Services is equal to the State Plan rate for the same service.

The rate for Personal Care (Personal Attendant) is reviewed every 5 years to ensure it falls between the range of rates paid in surrounding states for a similar service.

When rates need to be updated, a proposed rate is calculated based on the existing rate methodology by the OA. Proposed rates are reviewed by the SMA. Review and oversight occurs both at the OA and SMA levels including review of processes and procedures for determining the rate, and validating the data used to determine the rate. This takes place each time a rate is updated. All rate changes will be reviewed to identify whether the rate change adheres to existing policy, including the methodologies described in the implementation plan. In addition, the data used to derive a particular rate is evaluated and validated for completeness, accuracy, and reasonableness prior to a new rate being approved. If issues arise between the OA and the SMA, the SMA will collaborate with the OA to understand and resolve discrepancies. The SMA retains final approval authority for all rate changes.

When a change in rate determination methods or any change in rates occurs, the State will make the waiver amendment/renewal including the change available for a public comment period of no less than 30 days and comply with all requirements found in 42 CFR §447.205.

Information on rates is made available to all participants during the person-centered support planning process

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

For Providers who Voluntarily Reassign Payment to DHS/DSPD:

Requests for payments from the contracted providers are submitted to DHS/DSPD on form 520; payments are then made to the providers. DHS/DSPD submits billing claims to the Utah Department of Health (DOH) for reimbursement.

For individuals self-directing their personal attendant(s), the participant submits their staff time sheet(s) to the FMS Agent. The FMS Agent pays the claim(s) and submits a bill to DHS/DSPD on form 520. DHS/DSPD pays the FMS Agent and then submits the billing claim to DOH for reimbursement.

For providers who bill the MMIS directly:

Providers submit billing prior authorization forms to DSPD prior to submitting the claims to MMIS. DSPD will review the billing prior authorization forms submitted by the provider and will authorize the provider to bill the MMIS as long as the claims submitted on the billing prior authorization form are consistent with the service type, amount, frequency and duration as listed on the PCSP and budget.

• If the services listed on the billing prior authorization form are consistent with the PCSP and budget, DSPD will submit a notice of approval to the provider authorizing them to bill the MMIS.

• If the services listed on the billing prior authorization form are not consistent with the PCSP or

budget, billing for services will not be authorized by DSPD. DSPD will submit the denial notice to the provider that will include an explanation of why the prior authorization was denied. Once DSPD has approved the billing prior authorization forms, the provider will then submit claims directly thought the States' MMIS.

c. Certifying Public Expenditures *(select one)*:

X	**No. State or local government agencies do not certify expenditures for waiver services.**	
✦	**Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.** *Select at least one:*	
	×	**Certified Public Expenditures (CPE) of State Public Agencies**. Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-a.*)
	×	**Certified Public Expenditures (CPE) of Local Government Agencies**. Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-b.*)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

1. A participant's Medicaid eligibility is determined by the Office of Health and Eligibility within the Department of Workforce Services. The information is entered into the eligibility system which automates Medicaid eligibility decisions, benefits amounts, participants' notices and administrative reports. The eligibility system also interfaces with other governmental agencies such as, Social Security, Employment Security, and the Internal Revenue Service. The system is a Federally-Approved Management Information System (FAMIS). In Utah, the following programs are accessed through the eligibility system: Temporary Assistance for Needy Families (TANF), Medicaid, Food Stamps, and two state-administered programs - General Assistance and the Primary Care Network (PCN). MMIS accesses the eligibility system to ensure the participant is Medicaid eligible before payment of claims is made. Both CAPS (DHS provider payment system) and MMIS contain edits to help ensure that no payment is ever rendered to Medicaid ineligible recipients or providers. CAPS queries the eligibility system for each claim to determine Medicaid eligibility before that claim is submitted to MMIS for reimbursement. Claims for which Medicaid eligibility is not verified are excluded from the batch-processed claims submitted by CAPS to MMIS for FFP reimbursements. DHS/DSPD providers are paid through CAPS, and only after Medicaid eligibility of both recipient and provider is verified through MMIS is federal participation received by DHS/DSPD.

2. Post-payment reviews are conducted by the Medicaid agency; reviews of a sample of PCSPs and Medicaid claims histories to ensure: (1) all of the services required by the participant are identified in the PCSP, (2) that the participant is receiving the services identified in the PCSP and (3) that Medicaid reimbursement is not claimed for waiver services which were not included in the PCSP. The sample size for each review will be sufficient to provide a confidence level equal to 95% and a confidence interval equal to 5.

3. The SMA will perform an annual post payment review of claims that are paid to providers through CAPS. The review will verify that the rates paid to providers through CAPS are equal to the rates paid to DSPD through the MMIS.

Also, in addition to authorizing time sheets, each month the participant receives a report from the FMS agent detailing the service utilization. This report can be compared to the services that were actually provided.

The administrative case manager is responsible to have frequent and ongoing interactions with waiver participants and is expected to monitor service utilization and assure services provided continue to meet the participant's needs on an ongoing basis.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR § 92.42.

APPENDIX I-3: Payment

a. Method of payments — MMIS *(select one)*:

✦	**Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
✦	**Payments for some, but not all, waiver services are made through an approved MMIS.** Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64.
X	**Payments for waiver services are not made through an approved MMIS.** Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:
	a) The Waiver services that are not paid through an approved MMIS Payment for all waiver services are made through an approved MMIS eventually. However, for providers that voluntarily reassign payment to the Department of Human Services (DHS), initially payments for waiver services are paid to providers through the DHS Contract, Approval and Provider System (CAPS). (b) The process for making such payments and the entity that processes payments Waiver services providers bill the DHS using an electronic claim that is entered into the CAPS system. The CAPS system has edits in place that will deny payment for reasons such as exceeding the maximum allowable number of approved units or maximum allowable rates, etc. Providers are reimbursed by DHS with either a paper check or an electronic funds transfer as per the provider's preference. DHS then submits a file of all claims paid through CAPS to the SMA. The claims are then entered into the MMIS for reimbursement to the DHS. The SMA makes payment to DHS through an Intergovernmental Transfer of Funds (IGT). Each claim is individually identifiable at the level of the participant, provider, HCPCS and units of service paid. (c) How an audit trail is maintained for all State and Federal funds expended outside the MMIS The audit trail outside the MMIS is maintained in the CAPS system and the USTEPS Provider Interface System (UPI). (d) The basis for the draw of Federal funds and claiming of these expenditures on the CMS-64 As stated previously all waiver service payments are eventually made through an approved MMIS and this is the basis for the draw of Federal funds and claiming of these

	expenditures on the CMS-64. CAPS along with supporting documentation and claim information processed through MMIS provide audit support. Each PCSP must specify the amount, frequency and duration of prescribed services and is documented in the Utah Systems for Tracking Eligibility, Planning and Services (USTEPS) by administrative case managers and result in payment authorizations within CAPS. Payment authorizations result in the generation of provider billings. Provider claims are accompanied by eligibility codes that detail whether services qualify for FFP. Claims for services rendered under Medicaid eligibility are then ported to MMIS where recipient and provider eligibility are verified and claims that are determined to be eligible for FFP result in reimbursement to DHS/DSPD. Individual claim information is documented in MMIS. Utah DOH/DSPD IGT Process 1. The Department of Health (DOH) estimates the state seed amount for the quarter. 2. The DOH sends the IGT request to DHS for the estimated amount. 3. DHS processes the IGT request. 4. DHS approves the request. 5. DOH receives the funds before the start of the quarter. 6. At the end of the quarter, DOH determines the actual seed amount based on the paid claims. 7. The DOH sends the IGT request to DHS for the actual paid amount. 8. DHS approves the IGT request and DOH receives the funds. 9. DOH refunds the estimated amount to DHS via an IGT.
✦	**Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.** Describe how payments are made to the managed care entity or entities:

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

×	**The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
×	**The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
X	**The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.** Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:
	DHS/DSPD serves as the governmental entity that pays for waiver claims for providers who voluntarily reassign payment to DHS and DHS will pay for all services provided by the waiver when they are delivered by qualified providers according to the PCSP. DSPD receives claims electronically through an interface in the USTEPS Provider Interface (UPI)

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	system. Upon receipt, claims are automatically validated against the Person Centered Plan Budget for accuracy (amount, duration, and frequency). Valid claims are forwarded on to the assigned caseworker for approval. Approved claims are then forwarded to DSPD fiscal personnel for additional review and approval. Claims approved by DSPD fiscal personnel are then submitted to CAPS by DSPD data entry personnel for payment. All approved claims are paid directly to the providers by the DHS CAPS system. DSPD then submits billing claims to DOH for reimbursement. DSPD has internal controls in place to assure providers paid through the CAPS system receive payment that is equal to the payment DSPD receives from DOH including a comparison of DOH's MMIS Reference File rates with DSPD's CAPS rates for the same service, as per the DOH rate sheet provided each year. A comparison of MMIS HCPCS code/rate information with corresponding CAPS service code/rate information is implemented and documented via screen prints on a copy of a rate chart spreadsheet. This is completed before the beginning of each fiscal year when rates are generally adjusted, but a periodic review of CAPS to MMIS rates is completed throughout the year. Post rate adjustment billing detail is reviewed closely to ensure the agreed rates are correct on the claims submitted for reimbursement, as is the claims reimbursement detail. The SMA will perform an annual post payment review of claims that are paid to providers through CAPS. The review will verify that the rates paid to providers through CAPS are equal to the rates paid to DSPD through the MMIS. The rates schedules are coordinated between DOH and DSPD and the individual systems. In the event of a retro effective date, DOH and DSPD would coordinate the rate change in their system and DHS resubmit the previously paid claims through the MMIS system to be reprocessed. In the event of a retro effective rate change the following would occur: 1. The rates schedules would be coordinated between DOH and DSPD. 2. Providers would be notified of the rate change. 3. DSPD would have the rate set to the correct amount in CAPS and the claims would be reprocessed reflecting the new rate. 4. Providers payments would reflect the new rate. 5. The MMIS system would have the rate set at the correct amount and the affected claims would be reprocessed. 6. DSPD would receive their IGT that reflects the new rate. Providers are informed of their ability to direct bill Medicaid in their contract with the OA. FMS agencies also assist in the payment of Personal Attendant providers who may be hired by waiver participants through self-administered services. FMS agencies collect time sheets from the employee's/waiver participants and process them through CAPS or the MMIS. FMS agencies are contracted with the OA and receive annual audits verifying that they meet provider qualifications as well as the review of payments they have completed on behalf of waiver participants and providers.
×	**Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.** Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

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c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

X	**No**. **The State does not make supplemental or enhanced payments for waiver services.**
✦	**Yes**. **The State makes supplemental or enhanced payments for waiver services.** Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

X	**No**. **State or local government providers do not receive payment for waiver services.** *Do not complete Item I-3-e.*
✦	**Yes**. **State or local government providers receive payment for waiver services.** *Complete item I-3-e.* Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish. *Complete item I-3-e.*

e. **Amount of Payment to State or Local Government Providers**.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one*:

✦	**The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
✦	**The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**

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✦	**The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.** Describe the recoupment process:

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

X	**Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
✦	**Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.** Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

✦	**No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
X	**Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).** Specify the governmental agency (or agencies) to which reassignment may be made.
	DHS is the governmental agency to which reassignment is made.

ii. Organized Health Care Delivery System. *Select one:*

X	**No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
✦	**Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.** Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is

	assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

X	**The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
✦	**The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.** Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and (d) how payments are made to the health plans.
✦	**This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

APPENDIX I-4: Non-Federal Matching Funds

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one:*

×	**Appropriation of State Tax Revenues to the State Medicaid agency**
X	**Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.** If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:
	State tax revenues, or general funds, are appropriated directly to DHS by the Utah State Legislature. DSPD, which resides within DHS, receives the appropriated funds. DSPD transfers the funds to the SMA via an Intergovernmental Transfer (IGT). This prepayment transfer is based on estimates for the upcoming quarter and takes place approximately 15 days before each new quarter. At the end of each quarter, the SMA will perform a reconciliation of the actual State match obligation and the prepaid amount.
×	**Other State Level Source(s) of Funds.** Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select one:*

	Not Applicable. There are no local government level sources of funds utilized as the non-federal share.	
x	**Applicable** *Check each that applies:*	
	×	**Appropriation of Local Government Revenues.** Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

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	×	**Other Local Government Level Source(s) of Funds.** Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:
		The source of the funding from UTA is local sales and use taxes. The funds are publicly approved sales tax revenues levied by the cities and counties within UTA's service district. The taxes are collected quarterly from businesses from the sale of retail goods. The sales tax revenues are given to the transit authority for the operation of a local public transportation agency.

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds . *Select one:*

X	**None of the specified sources of funds contribute to the non-federal share of computable waiver costs.**	
✦	**The following source(s) are used.** *Check each that applies.*	
	×	**Health care-related taxes or fees**
	×	**Provider-related donations**
	×	**Federal funds**
	For each source of funds indicated above, describe the source of the funds in detail:	

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APPENDIX I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

X	**No services under this waiver are furnished in residential settings other than the private residence of the individual.**
✦	**As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

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APPENDIX I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.
Select one:

X	**No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
✦	**Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.** The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

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APPENDIX I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

X	**No. The State does not impose a co-payment or similar charge upon participants for waiver services.** (*Do not complete the remaining items; proceed to Item I-7-b*).
✦	**Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.** (*Complete the remaining items*)

i. Co-Pay Arrangement

Specify the types of co-pay arrangements that are imposed on waiver participants *(check each that applies)*:

	Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*
×	**Nominal deductible**
×	**Coinsurance**
×	**Co-Payment**
×	**Other charge** *Specify*:

ii Participants Subject to Co-pay Charges for Waiver Services.

Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-7-a-iii and the groups for whom such charges are excluded

iii. Amount of Co-Pay Charges for Waiver Services. The following table lists the waiver services defined in C-1/C-3 for which a charge is made, the amount of the charge, and the basis for determining the charge.

Waiver Service	Charge	
	Amount	**Basis**

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iv. Cumulative Maximum Charges.

Indicate whether there is a cumulative maximum amount for all co-payment charges to a waiver participant *(select one)*:

✦	**There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.**
✦	**There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.** Specify the cumulative maximum and the time period to which the maximum applies:

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one:*

X	**No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
✦	**Yes**. **The State imposes a premium, enrollment fee or similar cost-sharing arrangement.** Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income (c) the groups of participants subject to cost-sharing and the groups who are excluded~~;~~ and (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

Appendix J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care *(specify)*:	Nursing Facility						
Col. 1	**Col. 2**	**Col. 3**	**Col. 4**	**Col. 5**	**Col. 6**	**Col. 7**	**Col. 8**
Year	**Factor D**	**Factor D′**	**Total: D+D′**	**Factor G**	**Factor G′**	**Total: G+G′**	**Difference (Column 7 less Column 4)**
1	$24,907.73	$16,525.14	$41,432.87	$74,368.05	$7,092.00	$81,460.05	$40,027.18
2	$24,907.73	$16,525.14	$41,432.87	$74,368.05	$7,092.00	$81,460.05	$40,027.18
3	$24,907.73	$16,525.14	$41,432.87	$74,368.05	$7,092.00	$81,460.05	$40,027.18
4	$24,907.73	$16,525.14	$41,432.87	$74,368.05	$7,092.00	$81,460.05	$40,027.18
5	$24,907.73	$16,525.14	$41,432.87	$74,368.05	$7,092.00	$81,460.05	$40,027.18

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Appendix J-2: Derivation of Estimates

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care: Nursing Facility	Level of Care:
Year 1	105	105	
Year 2	105	105	
Year 3	105	105	
Year 4 (only appears if applicable based on Item 1-C)	105	105	
Year 5 (only appears if applicable based on Item 1-C)	105	105	

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in Item J-2-a.

Average Length of Stay (LOS) = 353 days
- Used the actual LOS from fiscal years FY19

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

- All calculations are based off the actual amounts from WY4/5 Utilization
- Units Per User is the average units per user for rounded to the next whole number
- Estimates may have had slight adjustments if trending data indicated that they may not be reflective of anticipated utilization

ii. Factor D′ Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

- All calculations are based off the actual amounts for FY19
- The state utilizes the MMIS Categories of Service and Provider Type functionality to account

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for and exclude the costs of prescribed drugs from D'

iii. Factor G Derivation. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

- Used actual average nursing home cost per day for FY19 and multiplied by actual PD Waiver LOS to get fiscal year base estimates

iv. Factor G′ Derivation. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

- Used actual average nursing home cost per day for FY19 and multiplied by actual PD Waiver LOS to get fiscal year base estimates

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services	
Personal Attendant Services	manage components
Financial Management Services	manage components
Personal Emergency Response Systems (PERS)	manage components
Specialized Medical Equipment and Supplies - Monthly Fee	manage components
Specialized Medical Equipment and Supplies - Purchase, Installation, Removal, Replacement and Repair	manage components

d. Estimate of Factor D. *Select one:* Note: Selection below is new.

X	The waiver does not operate concurrently with a §1915(b) waiver. Complete Item J-2-d-i
✦	The waiver operates concurrently with a §1915(b) waiver. Complete Item J-2-d-ii

i. Estimate of Factor D – Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1(FY 22- 07/01/2021)					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Personal Attendant Services	15 Minute	105	6230	$3.75	$2,453,062.50
Financial Management Services	Monthly	105	11	$95.24	$110,002.20
Personal Emergency Response Services - Monthly Monitoring	Monthly	20	11	$30.05	$6,611.00
Personal Emergency Response Services - Purchase	Per Episode	1	1	$208.08	$208.08
Personal Emergency Response Services - Install & Testing	Per Episode	1	1	$24.28	$24.28
Specialized Medical Equipment - Monthly	Monthly	10	11	$42.08	$4,628.80
Specialized Medical Equipment - Purchase/Install/Removal/Replacement	Per Episode	1	8	$43.70	$349.60
Non-Medical Transportation (UTA)	Per trip	15	185	$6.30	$17,482.50
Non- Medical Transportation - UTA Bus Pass Purchase	Monthly	19	10	$120.75	$22,942.50
GRAND TOTAL:					$2,615,311.46
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					105
FACTOR D (Divide grand total by number of participants)					$24,907.73
AVERAGE LENGTH OF STAY ON THE WAIVER					353

State:	
Effective Date	

Waiver Year: Year 2					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Personal Attendant Services	15 Minute	105	6230	$3.75	$2,453,062.50
Financial Management Services	Monthly	105	11	$95.24	$110,002.20
Personal Emergency Response Services - Monthly Monitoring	Monthly	20	11	$30.05	$6,611.00
Personal Emergency Response Services - Purchase	Per Episode	1	1	$208.08	$208.08
Personal Emergency Response Services - Install & Testing	Per Episode	1	1	$24.28	$24.28
Specialized Medical Equipment - Monthly	Monthly	10	11	$42.08	$4,628.80
Specialized Medical Equipment - Purchase/Install/Removal/Replacement	Per Episode	1	8	$43.70	$349.60
Non-Medical Transportation (UTA)	Per trip	15	185	$6.30	$17,482.50
Non- Medical Transportation - UTA Bus Pass Purchase	Monthly	19	10	$120.75	$22,942.50
GRAND TOTAL:					$2,615,311.46
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					105
FACTOR D (Divide grand total by number of participants)					$24,907.73
AVERAGE LENGTH OF STAY ON THE WAIVER					353

State:	
Effective Date	

Waiver Year: Year 3					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Personal Attendant Services	15 Minute	105	6230	$3.75	$2,453,062.50
Financial Management Services	Monthly	105	11	$95.24	$110,002.20
Personal Emergency Response Services - Monthly Monitoring	Monthly	20	11	$30.05	$6,611.00
Personal Emergency Response Services - Purchase	Per Episode	1	1	$208.08	$208.08
Personal Emergency Response Services - Install & Testing	Per Episode	1	1	$24.28	$24.28
Specialized Medical Equipment - Monthly	Monthly	10	11	$42.08	$4,628.80
Specialized Medical Equipment - Purchase/Install/Removal/Replacement	Per Episode	1	8	$43.70	$349.60
Non-Medical Transportation (UTA)	Per trip	15	185	$6.30	$17,482.50
Non- Medical Transportation - UTA Bus Pass Purchase	Monthly	19	10	$120.75	$22,942.50
GRAND TOTAL:					$2,615,311.46
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					105
FACTOR D (Divide grand total by number of participants)					$24,907.73
AVERAGE LENGTH OF STAY ON THE WAIVER					353

State:	
Effective Date	

Waiver Year: Year 4 *(only appears if applicable based on Item 1-C)*					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Personal Attendant Services	15 Minute	105	6230	$3.75	$2,453,062.50
Financial Management Services	Monthly	105	11	$95.24	$110,002.20
Personal Emergency Response Services - Monthly Monitoring	Monthly	20	11	$30.05	$6,611.00
Personal Emergency Response Services - Purchase	Per Episode	1	1	$208.08	$208.08
Personal Emergency Response Services - Install & Testing	Per Episode	1	1	$24.28	$24.28
Specialized Medical Equipment - Monthly	Monthly	10	11	$42.08	$4,628.80
Specialized Medical Equipment - Purchase/Install/Removal/Replacement	Per Episode	1	8	$43.70	$349.60
Non-Medical Transportation (UTA)	Per trip	15	185	$6.30	$17,482.50
Non- Medical Transportation - UTA Bus Pass Purchase	Monthly	19	10	$120.75	$22,942.50
GRAND TOTAL:					$2,615,311.46
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					105
FACTOR D (Divide grand total by number of participants)					$24,907.73
AVERAGE LENGTH OF STAY ON THE WAIVER					353

State:	
Effective Date	

Waiver Year: Year 5 *(only appears if applicable based on Item 1-C)*					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Personal Attendant Services	15 Minute	105	6230	$3.75	$2,453,062.50
Financial Management Services	Monthly	105	11	$95.24	$110,002.20
Personal Emergency Response Services - Monthly Monitoring	Monthly	20	11	$30.05	$6,611.00
Personal Emergency Response Services - Purchase	Per Episode	1	1	$208.08	$208.08
Personal Emergency Response Services - Install & Testing	Per Episode	1	1	$24.28	$24.28
Specialized Medical Equipment - Monthly	Monthly	10	11	$42.08	$4,628.80
Specialized Medical Equipment - Purchase/Install/Removal/Replacement	Per Episode	1	8	$43.70	$349.60
Non-Medical Transportation (UTA)	Per trip	15	185	$6.30	$17,482.50
Non- Medical Transportation - UTA Bus Pass Purchase	Monthly	19	10	$120.75	$22,942.50
GRAND TOTAL:					$2,615,311.46
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					105
FACTOR D (Divide grand total by number of participants)					$24,907.73
AVERAGE LENGTH OF STAY ON THE WAIVER					353

State:	
Effective Date	

ii. Estimate of Factor D – Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1						
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
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	×					
	×					
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

State:	
Effective Date	

Waiver Year: Year 2						
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

State:	
Effective Date	

Waiver Year: Year 3						
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

State:	
Effective Date	

Waiver Year: Year 4 (only appears if applicable based on Item 1-C)						
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

State:	
Effective Date	

Waiver Year: Year 5 (only appears if applicable based on Item 1-C)						
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

State:	
Effective Date	